VOLUME 13

THE CHILD

JULY 1948

to JUNE 1949

FEDERAL SECURITY AGENCY Social Security Administration • Children's Bureau

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THE CHILD

Volume 13, July 1948 to June 1949

204069—52—vol. 13

U. S. GOVERNMENT PRINTING OFFICE: 1952

JULY • 1948

the CHILD

CHILDREN IN A FREE SOCIETY

KATHARINE F. LENROOT, *Chief, Children's Bureau*

YOU who are graduating today have had a rich opportunity to make your own the cultural heritage of the human race. Many of you interrupted your education to endure great hardship and peril in defense of our Nation and the principles for which it stands. Then you returned to your studies with experience and a sense of direction which are characteristic of maturity. Many of you already have taken on the responsibility of a family, and have made homes in a simple fashion and with a minimum of financial resources. Now the graduates of Tulane University are entering into professional life as lawyers, physicians, social workers, or teachers; or into the business world; or into scientific and technical pursuits, enlarging and applying human knowledge. Today is a time for assessing what your university experience has meant to you, and the direction you wish to travel as you enter into the responsibilities and meet the challenge of a productive, scientific, or professional life.

In the few minutes at my disposal I can do no more than share with you some reflections growing out of 36 years of life and work since I received my bachelor's degree from the University of Wisconsin. Because my efforts have been directed toward advancing the health, growth, and well-being of children, I shall ask you to think about the problems the world faces today in terms of children.

First I would remind you that social institutions are mortal, but childhood is immortal. Every institution, no matter how nobly conceived, how idealistic its purposes, has within it the seeds of decay. Why is this so? Because of the imperfections of the men and women who at any given moment are the guiding personalities of the institution, because of the danger that in their love of power they will substitute means for ends, and because of the hazards of inertia and narrow self-interest on the part of their followers.

In the phenomena of birth and death we have the ever-recurring freshness of childhood, growing toward maturity and in turn being replaced by youth. Lecompte du Noüy, in Human Destiny, tracing the evolution of life from the inorganic through asexual reproduction, to sexual reproduction and the evolution of man, has said that death has prepared the way for the advent of human liberty. "It is the ephemeral individual," he points out, "who constitutes the primordial element of biological evolution, just as in the future the psychological individual will constitute the essential element of the evolution of spirit."

Recently a young scientist proclaimed his belief that the universe was born in an hour. Within that hour the entire drama of mankind, the idea of God Himself, as man was to apprehend and worship Him, were enfolded in embryo. So, too, in the human cycle, the moment of conception holds within itself the kernel of the entire life of the child as he grows into man or woman, and in his turn dies.

For 9 months the child lies warm and nourished within his mother's womb. For some 18 or 20 years he develops, acts, and responds, as a growing and protected human being, within the womb of the social environment in home, school, church, and neighborhood. Walt Whitman has described the impact of the social environment upon the child:

"There was a child went forth every day,
And the first object he look'd upon, that object he became,
And that object became part of him for the day or a certain part of the day, or for many years or stretching cycles of years."

Would you desire a key with which to unlock the paradox of history, to arrest the decay which threatens all human institutions, to neutralize the discovery of the atomic bomb? It is found in the rearing of children. A high official of the United Nations, Dr. Brock Chisholm, Executive Secretary,

Our purpose must be to enable children from their earliest infancy to develop emotional security.

Commencement address given at Tulane University, New Orleans, La., June 2, 1948.

Interim Commission of the World Health Organization, said recently: "The biggest business in the world and the most important business in the world, the business which outweighs all other values in the world, is the business of rearing children." It is a truism to say that if we could reshape the life of one generation we could reshape the world. Hitler understood this and reshaped German youth to his own evil ends. If we and our fellowmen in other lands understand this, we can build a world of peace, security, and freedom.

We need not be concerned about institutions if we are sufficiently concerned about people, and our concern for people must begin with the child.

Whether or not you yourselves have already undertaken the responsibilities of home and parenthood, you cannot escape concern about children. You are all drafted for a part in the most challenging task that any generation has faced—the task of preparing children and young people for life in an age in which man must shape all institutions to human ends or be utterly destroyed by them.

Altering the conditions of life for children means altering ourselves. You will have to be wiser and better parents than your own parents were, great as is the heritage with which they have endowed you, if your children are to be better and wiser citizens than you will be able to be, with all your youth and promise. The tests to which you and your children will be subjected, the choices that you and they will have to make, will probably be far more critical, measured in terms of human destiny, than those which challenged your parents.

There are just two things that are essential to childhood—love and example. Of these, the greatest is love.

Our people are great because they have been greatly loved. Our forebears crossed the ocean and conquered a wilderness for the sake of greater opportunity for their children. The resilience of our democracy is due to the love and care which parents have given their children throughout our history. Infant mortality has been cut two-thirds in a generation, mainly because mothers were eager to take advantage of all that science was able to teach them about taking care of their children.

The midcentury White House Conference will stress "The child in his family and community."

In any group, whether on a college campus, in industry, or in any place where people assemble, a certain percentage of people are lonely, frustrated, feeling themselves unwanted and unloved. These are the people who are likely to fail in marriage, who find it difficult to relate themselves effectively to other people at work, at play, or in world affairs. As parents they are either cold and neglectful, or overanxious, overpossessive, and dominating.

One child in every 20, on the basis of the present rates of commitment, is destined to spend part of his life in an institution for mental patients. Psychiatrists tell us that the mental breakdowns so prevalent today, and the neurotic personality patterns antecedent to or just escaping mental breakdown, are largely the result of lack of emotional security in early childhood.

How child attains security

The outgoing, enfolding, unselfish love of mature parents is the soil in which personal security grows. Such security is the basis for successful participation in family and community life and in the affairs of the Nation and the world. We would not have had to contend against Hitler or his Nazi followers had German children of that period generally had a firm foundation for responsible citizenship. In full appreciation of all that our mothers and fathers have meant to us—and done for us—the question we must consider is, can we love our children more wisely and more generously than even we ourselves were loved?

The answer is: Of course we can! The institution of marriage, though often wrecked by the immaturity of the partners, offers a warmth of relationship which can be healing and building in its effects. For many of those very far removed from mental health, salvation, though difficult, can be obtained. Scientific application of the principles of psychiatry, and provision of more adequate and more widely utilized resources for psychotherapy, can do much. Many of our churches now emphasize a form of counseling, in which the insights of religion and mental hygiene enrich each other. A concerted effort to surround all children with the kind of love that is essential to both their physical and mental health, and to provide expert help for parents and their children, if they show serious symptoms of insecurity, could remake the world.

A society that recognized the rearing of children as its most important task would test all social institutions by their effect upon the emotional security of childhood. Such a society would ask, "Does the medical and nursing care given the expectant mother, the mother in childbirth, and the newborn infant, directly encourage that warmth of relationship between mother and child, expressed in nursing, cuddling, and other ways, which is so important even in earliest infancy and supplies the foundation upon which secure person-

ality will be built?" Hospital administrators are beginning to see that separate nurseries for newborn babies must be abolished and the baby given care in the room with the mother, where the mother and the father, too, can come to know him as an individual.

Do the conditions of family life, the relationships between parents, the housing available to the family, the responsibilities that the mother may have for earning part of the family income, interfere with or promote the fulfillment of the emotional needs of the young child? How can the conditions of family life be modified so as to make it possible for children to have greater security?

Do parents of young children cooperate actively in making warm and friendly the neighborhood in which they live, and the influences brought to bear upon the child as he has his first contacts outside the home?

Do physicians, nurses, teachers, social workers, and recreation leaders have the insights and attitudes required if they are to help parents to surround their children from earliest infancy with warm, mature affection?

Emotional security cannot be acquired, for ourselves or for our children, by willing that it come to bless us. For adults to gain it is almost a matter of rebirth, to use the Biblical phrase. For children it can be assured to a far greater extent than at present through the concerted forethought and determination of parents and of all citizens.

To equip the oncoming generation

The second need of the child is for an example, a pattern from which he will depart only as he grows in experience and independence of thought and action.

The same United Nations official who called rearing children the biggest business in the world, said also that "the responsibility of parents and teachers of young children is to show children in their own persons and in their own habitual patterns the kind of citizenship that will make it possible for the human race to survive in the future." He added, "That has not been widely done in the past."

Here again, the question before us is how to give our children a better pattern than we ourselves have had, greatly as we love and cherish our parents and thankful as we are for what their example has meant to us.

Our school programs should be constantly guided by the aims of education in a free society.

In answering this question we must begin with consideration of the central idea and purpose of the evolving society to which we belong. We should then consider what qualities and characteristics must be developed in childhood and youth which will equip the oncoming generation to defend this purpose and advance toward its fuller realization. Having considered these two questions, we see that parents themselves must be deeply engaged in working for the attainment of these goals. Only as parents are so engaged can children be given the example, the pattern, by which they will be able to go farther than their parents could travel.

The Harvard report on General Education in a Free Society considered these questions from the point of view of the school; they must also be dealt with from the point of view of the home, and the community as a whole.

Man's dignity and recognition of his duty to his fellow men are accepted by the Harvard report as the central idea in our evolving social order. It named two touchstones of the liberated man: First, is he free; that is to say, is he able to judge and plan for himself, so that he can truly govern himself? Second, is he universal in his motives and sympathies?

To be able to judge and plan for himself, and at the same time to be universal in his motives and sympathies, a man must develop a sense of values by which he can measure people and events, and guide his own course with reference to them; he must be able to apprehend and relate himself to the good, and must understand and face the reality of evil. He must be willing to be an active agent in the society of which he is a part, not only assuming responsibility for the fulfillment of his own needs, but also sharing responsibility for the achievement of social aims. He must clearly see and understand the forces at work in himself, in his community, and in the world which would greatly limit or even obliterate human freedom or would impede social collaboration. He must feel himself so deeply involved in the struggle to protect and enlarge the sphere of human freedom that he loses himself in the cause for which he strives. At the same time he should feel deep within his own consciousness a disinterestedness, an objectivity, that is derived from the perspective of history and the idea of God.

The ideas of human freedom and social responsibility are old ideas; today they must be given renewed life throughout the world.

In the first place, individually and as citizens we must be deeply committed to the task of preparing children and youth, through love and example, to grow into the kind of citizens required for the survival and extension of freedom with responsibility.

Our central purpose must be to enable children from their earliest infancy to develop emotional security, and later to identify themselves with parents, teachers, and civic leaders who are united in a great effort to establish a social order throughout the world based on the dignity of the free man and his

responsibility for the common good.

These goals must be consciously sought after by our people, and must be incorporated in public policy as expressed through Federal, State, and local Governments.

Every 10 years since 1909 a National Conference on Children has been held on the call of the President of the United States, to assess the gains made, to review and restate needs, and then to outline goals for the next 10 years. Preparatory work for a midcentury White House Conference, to be held in 1950, is already under way. The conference will place special stress on "The child in his family and community." A conference of leaders from all but two of the States and Territories was held last March on the call of the Children's Bureau. This conference approved a plan to make the 2 years prior to the midcentury conference a period of study and action in every State and in local communities, with the leadership of committees on which public officials and citizens are represented. Federal agencies and national voluntary organizations will also cooperate in this undertaking.

We need research in child life

What are some of the aspects of our national life which will need to receive special consideration in the next 2 years?

We are spending hundreds of millions of dollars in mastering the secrets of the universe and large amounts are going into the study of atomic energy. In contrast, infinitesimal amounts are expended in learning how to develop those traits in children that will equip them, when adults, to use atomic energy for the service, not the destruction, of mankind. Successful research in child life, as in natural science, must be based on cooperative effort. The lessons learned by one student must be at the disposal of all. A Nation-wide plan for encouraging such research and providing for an exchange of information concerning it is urgently needed.

Preparation for parenthood and for the responsibilities of citizenship must be regarded as of equal importance with preparation for vocational or professional pursuits.

The material basis for family life must be strengthened, both as to income and housing. Family income in this country is disproportionate to the number of children. We have a system of social security. But it covers only certain risks, the benefits it provides are meager, and millions of families are excluded from its coverage. As to housing, in 1947, 2,800,000 families were living doubled up with other families. An additional 500,000 families were living in temporary housing, trailers, rooming houses, and other makeshift accommodations.

We must make continued and determined efforts to direct school programs to the child's needs for security and for growth in capacity for freedom and the exercise of social responsibility. To achieve this will require that a larger proportion of our national income be devoted to educational purposes, that Federal and State aid become more fully and equitably available, that we have greater numbers of teachers who are well-prepared and well-paid, that the administration and programs of our schools constantly be guided by the aims of education in a free society, and that economic barriers to educational opportunity be removed.

We must carry education for democratic living into programs of national preparedness. If young men at the age of 18 or 19 are to have a period of military training, let that training be directed first of all toward strengthening their capacities for living in accordance with the ideals and principles they are called upon to make secure.

Community services needed for physical and mental health and the social services needed to strengthen and conserve family life and provide for children without families or living in homes of neglect, conflict, or tension, are seriously inadequate. They must be expanded and improved. We have much to learn about the ways in which community health, educational, and social services can be adequately interrelated and directed toward common ends.

We need a great increase in professional personnel in all fields affecting children and youth. If we are to attain this, there must be greater expenditures for professional education, active recruitment policies, and means for extending educational opportunity to all who desire entrance into a professional field and have the capacity for professional life. Beyond this, we need to consider what common body of knowledge of child growth and development, supplemented by actual experience with children, should be part of the preparation of all professional persons who will be ministering to the health, educational, or social needs of children.

The problems of racial tension and the difficulties of establishing international understanding emphasize again the importance of developing in children capacity for effective relationships with other people, including those of different cultures and background. While we are called upon to do our part in protecting and encouraging free institutions abroad, we must with equal vigor defend freedom in our own communities.

One world for children

It is particularly important to support and extend international cooperation in matters pertaining to the health, education, and welfare of children, as well as in other fields of scientific and cultural endeavor. Fellows and students from other lands in our educational institutions and social and health agencies increase both their understanding and ours. Tulane University for years has been an important center for international exchange of this kind. The channels for scientific and cultural intercourse among peoples, whether in the Soviet or the Western orbit of influence, must be maintained and widened, so that we may grow toward the reality of "one world."

Just as the two essential needs of childhood are love and example, so the basis of parenthood is faith and expectancy. Your parents' faith in the goodness of life and their expectancy regarding your achievements brought you to this commencement day. Your faith in the divine purpose at work in the world and your expectancy regarding the infants that will be given to you to tend and rear will make it possible for them to grow in the love with which you will surround them, and to meet the tests which their maturity will bring.

We need not be concerned about institutions if we are sufficiently concerned about people. Our concern for people must begin with the child.

Reprints available in about 5 weeks

HOMEMAKERS HELP FINNISH MOTHERS

SIGRID LARSSON, R. N.

Director of Child Welfare and Health Activities, Mannerheim League for Child Welfare, Finland

WITH the growth of public-health nursing in Finland, the need for homemakers has become better recognized. Public-health nurses feel they can do very little for a mother who is ill or having a baby unless there is somebody to care for the household, the children, the cattle, and the garden.

In 1930 the Mannerheim League for Child Welfare, which is a section of the Finnish Red Cross, added homemaker service to its program. At that time several of the league's 550 local chapters engaged "capable and reputable women" and sent them to homes where their help was needed.

The league found it difficult, however, to obtain the right type of women for this work. The league also believed that homemakers should be better prepared, that standards should be set up for their work, and that the work should be supervised.

Nothing was done until 1939, when a committee representing the State Board of Health, the State Board of Agriculture, and the Mannerheim League was appointed to plan for further development. This committee was later enlarged and became the standing homemaker-service committee of the Mannerheim League.

In accordance with the suggestions of the committee the league established a 5-month homemaking course for women 18–35 years of age who have previously taken a year's course in a State school of home economics. As these already have a good foundation in housekeeping, the homemaking course emphasizes child care. The students practice in children's institutions half the time, and for a short while in homes for old people. The training includes a short course in home nursing.

When the course is finished, the student gets a diploma, a badge, and a set of plain uniforms.

The homemaker is in close contact with the public-health nurse and the midwife, who introduces her to families where her help is needed.

The homemaker gets a monthly salary, and a kitchen and an additional room as living quarters. She has an 8-hour working day, 1 day free each week, and a 3-week vacation after a year of work.

At the end of 1946 about 300 trained homemakers were working in Finland, the majority employed by local chapters of the Mannerheim League. Many were paid by the local communities, and in some cases the community was ready to take over the service altogether when it had once proved its efficiency.

Many hospitals and firms employ homemakers and send them to homes while the mother is in the hospital, or when she has been recently discharged.

When a mother must be away from home the problem of caring for the children is the same the world over. These children in Finland are being cared for by a trained homemaker.

The league school now trains 125 homemakers yearly. A director for the homemaker service has been added to the staff of the league, and regulations for homemakers have been printed, and also forms for their daily records and monthly reports. Staff meetings with lecturers, discussions, and demonstrations are held regularly in different parts of the country. But the demand for trained homemakers is too great to be met adequately through the present training possibilities.

Among the first civil laws adopted in Finland after the war were laws requiring communities to have public-health nurses, 1 for each 4,000 of the population; trained midwives; and prenatal and child-health clinics. The State pays three-fourths of the cost of these services, and the local communities one-fourth.

It is now hoped that the State will complete this program by adding homemaker service. A bill providing such a service is before the Parliament. If it is passed communities will be required to employ trained homemakers, 1 for each 4,000 of the population; the State will pay three-fourths of the cost; the homemakers will get a State pension; and the State will either take over the training of homemakers or give financial support to private agencies who arrange for this training.

To meet the need of the Swedish-speaking part of the people—about one-ninth of the population—one of the Swedish schools for home economists trains some 15 homemakers yearly. These work under the supervision of the Foundation for the Health of the Swedish-speaking in Finland.

So far the homemaker service in Finland has proved to be very successful. The people are ready for it, and a homemaker seldom meets with difficulties when she enters a home. As the work is becoming better known and more highly esteemed, more and more girls of a good type and with the required background are applying for entrance to the courses.

A good homemaker service means relief of anxiety for mothers who are unable to care for their homes; and, above all, it provides better care for children when the mother is not at home to take care of them.

Reprints available in about 5 weeks

Mothers' club carries out project for children with rheumatic fever

MRS. RUTH B. LAKEMAN, *San Rafael, Calif.*

FOR the past year our Mothers' Club in Marin County, Calif., has been working to make the lives of young rheumatic-fever patients in our county happier.

The first step in planning this program, a year ago, was to go out and get the facts. We needed to know how many children in the county had rheumatic fever and what kind of care they were getting.

We then asked ourselves what could be done to lighten the load that such a child's parents were carrying?

In this connection, how much did these parents know about their child's illness?

And how much did the public know about rheumatic fever?

We set out to get the answer to the first question, about the number of rheumatic-fever patients, by asking every person we knew to tell us the name of any child known to have rheumatic fever. We wrote letters, we telephoned to people, we had items published in the newspapers. The visiting teacher and the school nurse helped to find many such children. And little by little we collected the information, so that at last we knew how big our problem was.

Then we learned that in Sonoma County, our neighboring county to the north, parents were sponsoring a rheumatic-fever association to study the disease as a public-health problem. The association invited the general public to its first meeting, and several mothers from our county went to it. The doctor who directs the rheumatic-fever program of the State department of health spoke at this meeting, urging the people to learn more about rheumatic fever so that children handicapped by this disease could be helped. The Marin County mothers came home fired with extra ambition for carrying out their rheumatic-fever project.

The next step was to organize the mothers of children with rheumatic fever and a few additional mothers into a study group. At the meetings of this group authentic information about the disease, provided by leading physicians, was distributed and discussed.

Most of these mothers, including myself, were caring for a child who had to remain in bed. All of us felt the need for more knowledge about rheumatic fever and for more training so that our children's progress toward health would be as rapid as possible.

Most of us knew little about rheumatic fever or realized why the child needed the kind of care that the doctor had prescribed. We did know that the doctor had told us to keep the child in bed for an indefinite period of time, although he looked and felt quite well. Some of our relatives and neighbors could not understand the requirement. Some of them thought the youngster's mother was just babying him.

We exchange experiences

After reading about rheumatic fever and discussing what we read with our families and friends, we began to see what the long rest period could do to help junior get well more rapidly. Friends learned that the child really was ill, that he was not just mother's pampered darling. They understood that the physician had the first and the last word as to what junior should and should not do, and that mother needed the family's help in carrying out these orders.

As the mothers exchanged ideas about their children with one another, gradually another need came to light. That was the need for proper equipment and training for the nurse-mother.

Several of the mothers had had a brief course in home nursing during the war years. And it occurred to the Mothers' Club to ask the Marin County Red Cross to give a course in the evening, so that mothers who were busy all day could take it. The Red Cross agreed to give such a course, and the mothers learned a great deal from it. The most important thing we learned was to understand the doctor's orders and to follow them exactly. One of the many other things we learned was to make the child more comfortable in bed by having the bed adjusted to daytime conditions as well as nighttime. Thus the child was more willing to stay in bed.

Some of the children whose treatment required that they stay in bed felt well and needed some occupation to keep them busy and happy, rather than bored and demanding their mothers' presence all the time.

Again the Mothers' Club turned to the Red Cross, and the Red Cross had the answer in its arts-and-skills service. This service set up classes for mothers in simple crafts—paper cutting, stenciling, paper folding, weaving, knitting—things that the children could do without overtaxing themselves.

Rest for the mother who must take care of a child with rheumatic fever was the next thing that the Mothers' Club took up. To give such mothers a regular weekly hour of rest from her constant attendance on her sick child, the Red Cross trained a group of college girls to be substitute mothers, or rather, substitute playmates. A girl so trained visits the child once a week, and stays about an hour, playing quiet games with him, or reading to him, or otherwise entertaining him. These girls are young enough to take the place of a normal playmate, but old enough to make sure that the games do not excite a child who must be quiet. The youngsters look forward to the weekly visit from their grown-up playmates. Of course, these visits are made only with the approval of the doctor in charge of the case.

Now there is a movement on the part of the Mothers' Club to become an organization to increase the general public's knowledge about rheumatic fever. We want to do all we can to help in furthering the research that physicians and other trained workers are now carrying on. And as our own children again go back to normal living we want to spend more time helping other mothers get better care for their child with rheumatic fever.

Reprints available in about 5 weeks

NEW NEEDS AND NEW APPROACHES IN FOSTER CARE

LEON H. RICHMAN

Executive Director, Bellefaire Regional Child Care Service and Jewish Children's Bureau of Cleveland

HISTORICALLY, poverty and its concomitant problems were the principal reasons for placing children away from their homes. Recognition of the injustice of depriving children of their families led to formulation of child-care principles by the first White House Conference on Dependent Children, in 1909, from which came the widely quoted statement, "Home life is the highest and finest product of civilization. It is the great molding force of mind and of character. Children should not be deprived of it except for urgent and compelling reasons."

It took our Federal Government more than a quarter of a century to implement this principle through the aid-to-dependent-children provisions of the Social Security Act, and later through the survivors-insurance provisions of the same act. These provisions have had a far-reaching effect on family life. The financial aid generally provides at least the minimum physical essentials of life. But in almost half the States administering aid to dependent children a reduction is applied to the family's budgetary need because of the agency's lack of funds. In one State the allowance is no more than 35 percent of the minimum budget. Furthermore, the budgetary need is sometimes determined on the basis of out-of-date cost-of-living figures, some of which were priced as far back as 1942. In my State there are poor counties that can provide only 60 percent of the budget to families receiving aid to dependent children, and 90 percent of what is provided is from Federal and State funds. This is social insecurity for these children—a real threat to the family.

At the 1940 White House Conference on Children in a Democracy, it was agreed that "the child is an indivisible whole as he grows from infancy to manhood and must be planned for and served as such." Our provisions for children, however, have been fragmentary. Federal funds are provided for aid to dependent children in their own homes, but not for these same children when they are placed away from home. Some States and counties provide funds for care of children in institutions but not in foster homes, and vice versa.

This clearly shows that it is something other than the welfare of children that determines our social planning. Federal and State child-welfare legislation has in the past been enacted piecemeal, at the expediency of the moment and for specific categories of children. It suffers from a lack of long-range planning, of coordination, and of coverage. At times one wonders if it is not fear rather than real concern for children that motivates many community provisions for them. Otherwise, how can we explain the widespread provisions for children with contagious diseases as compared with those for children with cerebral palsy or rheumatic fever? Similarly, society removes the delinquent from the community because he is a social menace, but shows little concern with the treatment he receives in the institution.

Again, when war conditions caused women to leave their homes and go into industry, the country provided day-care services for children. Once the war crisis was over, the day-care program was liquidated. The fact that a great number of mothers must go on working, and that the continuity of family life could be sustained if adequate care were provided for the children during the day, did not prevent the scuttling of the program.

More recently the public became aware that children must be protected to assure the future of society. Is the child not entitled to normal physical and emotional growth as a fellow human being with rights, as well as an investment to meet economic problems of the day and to protect the remote future of society?

Planning in the foster-care field today is still influenced by emergency provisions that were designed to meet immediate needs in periods of economic depression and of war. Child care is still presented to legislatures and to the public during fund-raising campaigns in terms of pity for the econ-

Based on papers presented at the Ohio Valley Regional Conference, Child Welfare League of America, March 1948, and at the National Conference of Jewish Social Welfare, May 1948.

omically disadvantaged and the orphaned child. A democracy that is based on respect for the individual and the dignity of man must be concerned with the welfare of every child, regardless of his social or economic position. A program of child welfare is more than merely giving food and shelter. It is social engineering, which lays the foundation for the future of our Nation.

Our programs have been operating under great stress because of lack of funds and of resources. The scarcity of foster homes has led to expedients that are fraught with danger. Children are dumped into detention homes or placed in overcrowded houses that are expected to serve as foster homes for more children than they are prepared to receive. Healthy babies are kept in hospitals and in maternity-home nurseries.

If the problem is to be met intelligently, it must first be faced squarely. And the longer the delay the more serious the situation will become. It is essential to take stock of what is happening, reevaluate some of the basic concepts that have guided the foster-care field, and consider immediate steps to be taken. Professional child-care workers have a responsibility to interpret to the community the needs of children and the standards for fulfilling these needs.

For about 40 years the guiding principle in child care has been that children deprived of their own homes are better off under the care of foster families than of institutions. No one questions the soundness of this general principle, but its current application must be in accordance with the reality of 1948. The problems concerning children are different under changing conditions. What were some of the prevailing conditions at the time this principle was first enunciated in 1909, and what have been the changes that have interfered with its fulfillment?

Times have changed

Everyone knows that the American family has undergone fundamental changes during the past four decades. Foster families as well as other families have been affected. Increased tempo of life, economic depression, great mobility of population, physical and emotional strains of war and postwar readjustment, fear and insecurity in a changing world all have made for unstable family relationships that have played havoc with children's lives. Studies in war areas have shown that with parental security a child is relatively little affected by external threats of danger.

Forty years ago, when the majority of the children were brought to agencies for economic reasons, no public funds were available for children except near-starvation relief. Headway has been made toward increased public acceptance of responsibility for child care. Although the inadequacies of the social-security provisions still force many mothers to seek placement for their children, thousands of children are spared such separation from their families. The program for aid to dependent children provided in June 1947 for 1,009,475 children; and the survivors insurance program provided for 499,246, the majority of the children in the latter group living at home.

The dependent children of earlier years came into placement because of the death of a parent or parents. Parents live longer now, and the number of full or half orphans away from home is insignificant as compared with 40 years ago. The maternal mortality rate has been decreasing constantly. In 1945 the rate was the lowest in the more than 30 years that comparable figures have been collected. No longer do most children who are placed in foster care remain there from early childhood until they can become self-supporting. Most of them return to their families after a few years, even though it may not always be in their best interests and it may be contrary to agency plan.

The child-care field was slow in recognizing this change, which called for agency reorientation in planning placement for children who had one or both parents living, and a need for more intensive work on parent-child relationship. The impact of the parents' desire for recognition was too great to be ignored indefinitely, but agencies responded by calling it "interference."

With greater understanding of the dynamics of the parent-child relationship, and acceptance of the principle of self-determination for parents, as well as for other people who seek help, children's agencies have begun to reexamine their approach to parents.

Very little thought, however, has been given to the effect of this change on foster-home placement. Foster families cannot serve all children as substitute families in the same sense as it was understood in 1909.

Many children now refuse to consider the foster family as a substitute for their own family, which may be either intact or broken, but which has a parent in it. Some parents, too, may feel that their status is threatened by a foster family that wishes to live up to the agency's expectation of absorbing the foster child into their family. It is clear that a new definition of foster-home care for these children must be evolved to overcome the current confusion.

Though foster-family day care and full-time foster-family care are not identical, we may be able to learn something from day care, in which the foster parents and the natural parents share in caring for the children.

Foster child needs own parents

Would some placements be more successful if a different approach were used in keeping to a minimum the amount of emotional separation necessary between the child and parent during placement? Could some parents acquire a real sense of continued responsibility for the child in placement, not only through making payments for his care but in direct responsibility for his clothing and allowance? Could the agency make it possible for parent and child to do little things together to preserve the bond between them?

Any child who is separated from his parents for any cause needs constant reassurance that he is wanted.

The death of a parent is, of course, a serious loss to a child, but if he has had an early satisfying experience with his parents, this will help him to trust adults and to accept from them the affection he needs for normal development. Most children who come into placement now are much more hurt by life than were the orphaned children of earlier years. Their problems are more severe than those caused by the death of a parent, as these problems reflect the parents' inability or refusal to act as a parent.

An increasing number of children

come from homes broken through divorce, separation, or desertion. To the child these separations have little meaning in terms of the parents' incompatibility, but rather as rejection of him. Moreover, family disorganization is usually a gradual process.

If children are nurtured in a family dominated by friction, frustration, and hostility, this undermines their security long before they are taken away from their homes for placement. Many of these children had been used as a weapon by one parent to punish the other, and they lost faith in adults.

Children and foster parents suffer

The personalized environment of the foster family and its demands for a give-and-take relationship are more than these children can stand at the time of placement. The kind of skillful help they need cannot always be found in a foster home. These are the unhappy problem children who wreck one foster home after another and defy the best case-work skills; their own lot is worsened in placement rather than improved.

The significance of this problem can be appreciated when noting the increased rate of only one form of separation—divorce. In 1910 there was one divorce to every seven marriages; by 1946 the figure jumped to one divorce to every three marriages.

Another serious problem is the care of infants and toddlers. With the continuing increase in the birth rate, the present foster-home crisis cannot be dismissed as temporary. This problem became apparent even before the war. The makeshift arrangements now provided for young children are harmful to their development. When they are moved out of detention homes and hospitals they are placed in institutions that are not equipped in plant and personnel to give them the necessary physical and emotional care.

Likewise, foster homes, if burdened with five to eight infants, without adequate help, cannot serve the babies any better than institutions. An adequate supply of foster homes is not likely to develop within the next few years to meet the increased need for this age group. Neither recruiting efforts nor hope and wishful thinking have solved the problem. We must face the facts and provide suitable substitute facilities that will assure babies of maximum opportunities for growth and development as long as the foster-home shortage continues. We must not allow the present obstacles to discourage us from promoting the standard of service in which we believe.

The current housing shortage makes it impossible to develop enough subsidized foster homes for all the babies that need them. In most communities enough houses for this purpose cannot be rented, especially in urban centers, where the problem is most acute.

Some agencies have been experimenting with transferring selected unattached infants directly from hospitals into prospective adoptive homes on a foster-home basis, keeping them there until it is determined if the child is adoptable. Such placement is usually made only if the background of the child is known and the mother's plan to surrender him is certain.

There are risks, of course, involved in such placements, and the agencies are aware of them. It is too early to know what the physical and psychological development of these children will be, and whether the home chosen will prove to be suitable for the particular child.

It is hoped that agencies using this type of placement will share their experiences with other agencies. The needs are great, and the use of new methods should be encouraged as long as they are tried responsibly and evaluated objectively.

Some institutions have made space available for babies and preschool children, though the experience of children's agencies and child-guidance clinics has demonstrated the deleterious effects of 24-hour group life on little children. Their physical and emotional needs require personalized, individual care which only a family can provide.

It is a fact, however, that circumstances have compelled agencies to use institutions or group homes for infants and preschool children. The danger of this is in the possibility of using standards that are applicable to older children when we are planning group care of very young children.

If little children are to live in institutions, it is essential that intelligent and kindly women who have a natural fondness for young children take care of them. Also the staff has to be large enough to allow at all times one adult for three babies who are on the same schedule, and one adult for two babies who are on different schedules.

For care of toddlers it would seem necessary to plan to have one adult for each three children, as some of the staff will have other duties than direct care of the children. Principles of nursery-school education should be adapted to the needs of resident preschool children. Adequate salaries and comfortable living quarters should be provided.

These standards are proposed with full realization of the expense involved; they are the outgrowth of 3 years of sobering experience with a project for this age group. Attempts to economize by compromising with these standards have demonstrated that the babies' development is in direct ratio to the quality of service rendered. The importance of this period in a child's life demands the most tender care we can provide. Inadequate care tends to predispose a child to, or actually produce, behavior difficulties and later unsocial behavior.

Some agencies are meeting the problem by purchasing a house and setting up a foster family. The family agrees to care for a specific number of babies, and the agency guarantees a definite monthly income.

Whether babies are in a foster home or an institutional cottage, there should be ample space to allow for no more than three infants in a room, and preferably two. Six babies should be the maximum per unit. It makes little difference whether the program is under the auspices of a placement agency or an institution. It is the quality of care that matters. Specifically, it is adequate personal mothering by the same person that is of utmost importance. If it is necessary to resort to a group type of care, it should be limited to preadoptive infants and others requiring care for only a few months.

We must conserve foster homes

At no time in the history of foster-home placement have there been enough foster homes to meet the need. Some people maintain that the communities have reached the saturation point in their capacity to take all the children who should be in foster homes. To test this statement it is necessary to study

A baby's physical and emotional needs require individual care that only home life can provide.

the factors that are restricting the supply of foster homes. Placement of children who are not ready to benefit from a foster home has in some measure contributed to our present crisis. The housing shortage, low board rates, inflation, changes in family life, and lack of an effective community-relations program are some of the factors contributing to the problem. The home-finding problem cannot be studied without due attention to conservation of foster homes through adequacy of initial study; type of placement made; and case-work skill made available to the foster family, to the child in placement, and to the natural parents. There is a terrific waste in the loss of foster homes.

It is likely that out of such an inquiry will evolve a new concept of foster-home care. It may have to be recognized as a benevolent business instead of a benevolent act, and compensation for service may have to be viewed realistically. This point of view may shock those who feel that becoming a foster parent is a kind and humane deed, which cannot be measured in dollars and cents. The assumption that foster parents receive sufficient pleasure from the children to compensate for their efforts is much less true today. In most instances they have to share the children with the natural parents, which is a difficult task in itself, and caring for children is often anything but a pleasure.

Some agencies point to the fact that recent increases in board rates have brought little relief. Furthermore, the relentless rise in the cost of living has proceeded much faster than have these increases.

We have no reason to fear that compensation for service on a businesslike basis will lead to acceptance of foster families whose primary interest will be in the money. The whole field of social work has evolved from a voluntary to a paid basis, with benefit to the service. Agencies will be in a better position to require certain personal and intellectual qualifications of foster parents, which would facilitate their development through supervision and enhance their usefulness as well as their status.

Having reviewed the changes that have affected the foster-home field, let us consider institutions. Factors that undoubtedly influenced the child-care field in the past were the philosophy, program, and physical plan of institutions.

Institutions were of the large, congregate type, some of which housed several hundred children. They were slow in accepting mental-hygiene concepts and appreciation of the individual child and his needs. Their function was custodial; the program was routinized and rigid, and strict discipline ruled supreme.

It is understandable why responsible child-welfare leaders wanted to keep children out of such institutions. Though there are still a great number of institutions where the program is of this type, some have made great strides in recent years in developing the concept of a child-centered institution.

The modern, progressive institution is not concerned with mere shelter, food, and clothing, but is conscious of its responsibility for the emotional growth and social education of children. It recognizes that its unique contribution is education through guidance of group living. Case work and psychiatry help the individual child to merge with the group and, at the same time, enable him to develop his own potentialities and handle his conflicts constructively. Modern institutions provide children with opportunities for normal community relationships through extramural activities and through greater freedom of contact with friends and relatives. They are usually of the cottage type, housing about 8 to 15 children in each unit.

New institutional services needed

As with every other kind of social change, change in children's institutions is a slow process. These have been conditioned by older concepts and practices, and new trends must fight to gain acceptance. Institutions are still on the defensive, a position they assumed in the twenties during the controversy of institution versus foster home. The challenge that institutional care was more expensive must have struck a vulnerable spot, as institutions are still sensitive on this point. They cannot reduce fixed expenses, and they hesitate

to introduce needed new services because of the increased cost. Institutions are asked less frequently about their program than they are about their per capita cost, though the per capita cost has no meaning without reference to the quality of the service. Institutions are not sure yet of their place in the scheme of community planning for children.

Methods differ; purpose the same

Progress has been achieved in communities where there has been an integration or merger of case-work agencies offering foster-home care and of institutions. Such mergers are by-products of an effort on the part of communities to develop a program that meets changing conditions and community needs. It demonstrates an effort to create unity among separate but related child-care functions, none of which can be performed successfully without regard for the other.

Emphasis on the individual child in foster-home care in no way conflicts with the primary purpose of offering the child a constructive group experience in the institution. The object of both types of care is the same; that is, to facilitate the personal and social adjustment of the child. The methods differ, but each service supplements the other and has a specific contribution to make to the child's adjustment. The integration generally provides a central and continuous responsibility for children requiring help.

Something significant happens when an institution accepts a professional base for its functioning. It becomes a child-centered facility and not a mere shelter. It provides case work; and the principles of progressive education, of mental hygiene, and of group-work programs are incorporated in the program. The stay is shortened, and there is a freer use of foster homes for children whose needs have changed. The caliber of personnel improves and professional service is stressed.

As greater integration is achieved in child-care service, it will be possible to give more thought to specialization in the institutional field. Ultimately, communities will have to develop a mosaic of institutions for children, each offering services to a fairly homogeneous group. These institutions will be smaller than the present ones, but the services of one will complement instead of duplicating the other.

Who are the children the modern institution is to serve? It was stated earlier that the type of the children coming to agencies has changed. An increasing number present serious behavior and emotional problems. They are the children who wear out one foster home after another and disrupt the program of the ordinary institution. While we know how to help many of these children, communities mainly rely on old and inadequate resources to meet their need.

Agencies are reluctant to admit that foster homes and ordinary institutions cannot serve most of these children at the time they appear at the agencies' doorsteps. The children are unresponsive, distrustful of adults, suspicious of friendly overtures, and provocative. The average foster parent is inclined to get a sense of failure in trying to help these children, becomes discouraged, and asks for their removal. The children benefit little from the placement, and the agency loses what might have been good foster homes for other children.

No blanket solution

Foster-home service cannot meet the needs of all children. In the attempt to have the foster home serve all child-placement needs lies, in great measure, the cause for the present break-down of the foster-home program throughout the country. A serious byproduct of this kind of placement is the discouraging effect it has on potential foster-parent applicants.

To meet this problem some agencies are experimenting with temporary subsidized foster homes to determine whether or not disturbed children can take placement. These special-service homes are also used as a means of helping children and parents to test out their feelings about their separation. The shortage of foster homes limits use of this plan. The success of this experiment depends not only upon the supply of these special-service homes, but also upon the availability of regular foster homes and specialized institutions to absorb the children who are emotionally ready to move into them.

Other agencies have set up temporary study homes to determine children's needs. These study homes are actually small institutions. It is artificial, however, to separate study from treatment as distinct phases of child care. Furthermore, the temporary character of a study home is contrary to the needs of these children for a sense of stability, belonging, and a degree of permanence. The frequent transfer of children characteristic of this type of setting adds to the feeling of uncertainty and the state of suspension.

With the exception of children who require emergency care, it is possible during the course of the intake process to identify most children who require special care. Where should such care be provided? We must look to institutions for it. They must develop small units housing a maximum of 8 to 10 children. The quality of personnel is the crux of this type of program, particularly with cottage staff, who are responsible for the day-by-day life of the children. The best case-work and psychiatric staff will fail if the cottage personnel cannot understand the purpose of the program and cannot completely identify themselves with it.

The traditions of institutions will have to give way to a concept of scientific care and treatment. Their strength lies in their own values rather than in substituting for foster homes. The emphasis will have to be on personality development through spontaneous, rather than regimented, group life and through satisfying group activity. This type of institutional program is expensive. The Nation will have to decide whether or not it is wiser to invest in a sound child-care program than to spend exorbitant sums of money on correctional institutions and mental hospitals, when these children of today are the socially and emotionally maladjusted adults of tomorrow. The results of warped childhood are clearly reflected in the records of the selective-service boards and the domestic-relations courts throughout the country.

It is important to comment briefly on case work in institutions, since an increasing number of them have been setting up case-work programs. The case worker brings about individualization for the child in the group setting. He makes it possible for a child to move from one activity or contact to another

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STATES AND COUNTIES JOIN FORCES FOR WHITE HOUSE CONFERENCE

KATHERINE GLOVER

Information Consultant, Preparatory Activity White House Conference 1950, Children's Bureau

STATES and communities are gearing into action looking toward the 1950 White House Conference. Since the earliest stages, when the idea of the conference was launched by the National Commission on Children and Youth, it has been stressed that the needs of children would be considered where children are living—in their local communities.

The ideas, initiative, and cooperative action of State and local groups are helping to mold and shape the character of the conference. Even in the research that is necessary, although much of it will necessarily be on a Nation-wide basis, there will be participation and contribution by the individual States.

The purpose of such a plan is that the 2-year prologue of planning and action, as well as the conference itself and the follow-up, will enlist the widest possible participation and interest of people. This conference will weave into a unified effort the contributions of leaders in the professions, and other specialists, and a wide cross section of laymen, as well as of official agencies—Federal, State, and local—with the contributions of citizen groups.

A forecast of the realization of this hope begins to emerge as plans for State-wide programs get under way. It is evident that the vitality of these State programs will depend upon the effectiveness with which local communities are reached, upon the development of local leadership and responsibility. Interest and action, in short, in this national conference will stem from the persons closest to children. There will be a central committee, under the auspices of the National Commission on Children and Youth and the Children's Bureau, but there will also be a continuous filtering back and forth between this committee and the State and local groups.

Reports indicate that in the rural States particularly every effort is being made to get the program into the counties.

In **Alabama** coordinated planning for the White House Conference rests in the hands of the Alabama State Advisory Committee on Children and Youth. The committee has addressed to all county superintendents of education, county health officers, directors of public welfare, and farm- and home-demonstration agents, a request that they take the initiative in forming local children's advisory committees, or, where a local coordinating council already exists, that a subcommittee be appointed to serve in this capacity.

The objectives and recommendations of the 1950 Conference, as developed by the Conference on State Planning for Children and Youth held in Washington March 30–April 1, have been sent to the county leaders by the chairman of the State advisory committee as a basis on which to mobilize their local action.

Florida's Children's Commission, created a year ago by the State legislature, is the agency empowered with the responsibility for State participation in the White House Conference. Here, too, planning is in the direction of stimulating strong county action. Organization of companion committees in the 67 counties of the State to work for the interests of children and youth is under way. More than 630 officials and laymen have joined hands in this State-wide effort.

Included on the State commission are the State superintendent of public instruction, the State health officer, the State welfare commissioner, and the chairman of the crippled children's commission, as official members. Other members include representatives from the State congress of parent-teachers associations, the League of Women Voters, child-care service agencies and institutions, the federation of women's clubs, the State university, the American Legion, the churches, the civic clubs, the State bar association, and the county commissioners' association. The seven juvenile-court judges and a parole commissioner serve as the advisory members.

The members of the commission are assigned to six subcommittees, on juve-

Interest in the midcentury White House Conference will stem from those closest to children.

nile delinquency, education, recreation, child health, the dependent child, and legislation review.

Three broad tasks are outlined for each county children's committee:

1. To become acquainted with and list the needs of children in trouble, through a study of the delinquent youth, the dependent child, and child health.

2. To make a thorough survey of the resources within the borders of the county.

3. To kindle a consciousness of the welfare of children and youth in the hearts and minds of the citizens of each community.

The **North Dakota Youth Council** held a workshop on March 15, 1948, in the State capitol, to frame the goals the State would like to achieve by the time of the 1950 White House Conference.

A roster of goals was presented under the headings of health, education, and welfare. The fact that the health goals were classified under moral, physical, physiological, and mental health indicates the wide concept of health which is gaining ground. The education goals laid stress upon the strengthening of teacher training, particularly in training for guidance; they include the fields of family relations, of human relations in general, and of citizenship training.

The discussion of health stressed goals in the field of moral health, and the responsibility of the home and the church to promote these goals. Mental-hygiene education was emphasized for teachers, for children as part of the school curriculum, and for parents and the public; and wider use of counseling in the school program was urged. Specialized resources for children with personality problems were recommended, with more and better-trained personnel in this field.

The welfare goals stressed the strengthening of the family unit, the reawakening of spiritual values, and the stimulating of families to work and play together. They emphasized, among other things, the need for wide community participation in the interest of youth and the need for adequate housing.

The executive committee of the council was authorized to appoint in every community in the State an official representative to carry on the purposes of the council.

FOSTER CARE

(Continued from page 12)

with steadiness and consistency. It is necessary for a child to find some cohesion in an institution, just as he would find it in a family.

The magnitude of the child-care problem is such that it requires us to reevaluate our present methods of care and to develop new resources as indicated. It is a waste of human and financial resources to allow children to drift into types of placement that are unsuitable for their needs. Without minimizing the importance of foster-home placement for certain children, we must direct our attention to the new function that institutions must assume. Institutions geared to meet the needs of the dependent and orphan child must face the fact that such children will be coming in fewer numbers and that their programs must be changed to meet the needs of children whose behavior requires professional understanding and skillful treatment. The whole child-placement problem will be greatly eased, and the needs of children better met, if institutions take responsibility for children who require specialized care.

May plan for specialized care

After a period of treatment these children can make better use of foster-home placement in case they cannot be returned to their homes. The public agencies cannot be relieved of responsibility for the care of children who require specialized placement facilities. The private institutions, however, will have to assume major responsibility for demonstrating a standard of care that is commensurate with the needs of these difficult children. Until they develop their own specialized institutions as a part of their child-care program, the public agencies may purchase care for their children in these private institutions as they would hospital care.

The concept of foster-home placement has to change, as only a limited number of children require permanent substitute homes. Even after receiving temporary treatment in institutions most foster children will continue to need patient and understanding care from the foster family. We cannot depend on foster parents to take children for the satisfaction of having the child in their home. Compensation for foster-home care must be approached on a realistic basis, and adequate fees for service paid.

Community has stake in child care

It is obvious that improved child care will call for more public and private funds. The community has a right to know how effective are the programs they support. Statistical compilations of symptoms, success, and failure are meaningless without reference to the specific methods of prevention and treatment that have contributed to the end result. A comprehensive program of research in child care is essential for the welfare of the children as well as for protection of community investment. Research in social welfare is the most neglected area in our country. The Federal Government spent $625,000,000 in 1947 for all kinds of research, but except what was spent on health, practically none of this was spent in the children's field. The act of 1912 creating the Children's Bureau gave the Bureau a mandate to carry out research, but this phase of its program has never been adequately financed. Research should be national in scope, with support from both private and public funds. The most serious obstacles to social research are lack of well-defined methods, lack of trained research personnel, and pressure for quick results.

In conclusion, child care cannot be viewed apart from family welfare. It is therefore important to strengthen the forces that contribute to the stability of family life. Economic security is the first requirement, but family case work, homemaker service, and day care can contribute much. The public-assistance programs should provide a better standard of living and the needed social services to strengthen the family. The Federal and State social-insurance systems should provide greater coverage and be geared to the enhancement of family security. Our Nation will conserve its children when it learns to view child welfare as an investment in human welfare rather than as an expense.

Reprints available in about 5 weeks

• IN THE NEWS

For Nutrition of Children in War-Stricken Countries

A joint committee of the Food and Agriculture Organization of the United Nations and the World Health Organization Interim Commission has prepared a "Report on Child Nutrition" for the United Nations International Children's Emergency Fund.

This report describes the general condition of children in war-stricken countries of Europe and in China. It also specifies principles of nutrition to guide UNICEF in developing its operations. Finally it makes recommendations concerning supplementary feeding of pregnant and nursing women, infants, and older children, and, in an appendix, recommendations on calories and specific nutrients.

The report is available in the five official languages of the United Nations. Copies are available on request from United Nations International Children's Emergency Fund, 405 East Forty-second Street, New York 17, N. Y.

Excerpts from the report will be published in a future issue of *The Child*.

To Give Graduate Training in Public Health

Fellowships for 1 year of graduate training in public-health education leading to the master's degree are available under a grant from the National Foundation for Infantile Paralysis. Training may be taken in any accredited school of public health with a curriculum in health education leading to a graduate degree. While not specifically intended for training in mental-health education, work in this field may be taken with the approval of the school attended.

An applicant must be a citizen of the United States, or have declared his intention to become one, must have graduated from an approved college or university, with an educational background in the biological sciences, including chemistry, and must have had 3 years of experience or an advanced degree in public health or related fields, such as education, sociology, or welfare. Employees of State, or local health departments are not eligible. The age limit is 22 to 40.

Fellowships provide $100 a month plus tuition. Partial fellowships are available for veterans, supplementing the amount allowed for maintenance under the GI bill of rights.

Award of fellowships is made by an advisory subcommittee of the Public Health Service Committee on Training of Public Health Personnel. The committee is meeting at monthly intervals, and it is recommended that applications be submitted as soon as possible. Applicants must first be accepted by an approved school of public health before being considered for a fellowship.

Further information may be obtained by writing to the National Foundation for Infantile Paralysis, 120 Broadway, New York 5, N. Y.

Emphasis on Youth

It is significant that the Employment Service Review, monthly publication of the U. S. Employment Service, Department of Labor, devoted its entire May 1948 issue to the young worker entering the labor market.

The issue reveals an encouraging emphasis on youth which characterizes many of the U. S. Employment Service programs and points up the need for special attention to the problems of the young worker just entering the labor market.

The articles cover a wide range of subjects aimed to guide youth in crossing the bridge from school to work. They include practical examples of how schools and industry can maintain strong lines of communication and how schools can train graduates for jobs; an article on counseling, including an article on the counseling needs of rural youth; and one on the part a community program for youth plays in strengthening the efforts of the Employment Service in servicing young people, as well as other helpful topics.

• FOR YOUR BOOKSHELF

DEATHS OF PREMATURE INFANTS IN THE UNITED STATES, by Ethel C. Dunham, M. D. Federal Security Agency, Social Security Administration, U. S. Children's Bureau. Statistical Series, No. 2. Washington, 1947. 12 pp. Single copies free.

Premature birth takes a higher toll of infant life than any other condition, and it is one of the 10 leading causes of death among the general population of the United States.

Census figures on deaths attributed to premature birth, analyzed in this bulletin, show a decline in such deaths from 1935 to 1944, especially after 1937.

To save premature infants, the author says we must make increased efforts to prevent premature birth; get more detailed information on deaths now assigned to premature birth alone; spread knowledge of and facilities for the special care known to be needed by premature infants; and broaden through research the scope of knowledge in regard to problems of prematurity.

THE "FORCE" IN ENFORCEMENT, by Lazelle D. Alway. Illustrated by Ruth Senne. National Child Labor Committee, 419 Fourth Avenue, New York 16, N. Y. 9 pp. Mimeographed. Free.

Group study of child-labor laws and their enforcement becomes easy with the help of this pamphlet, which raises the questions that need to be asked, tells how to get the answers, and suggests what people can do to help support good child-labor laws and their enforcement.

The pamphlet lists other resource material on child-labor laws and standards available, free of charge from the National Child Labor Committee and from the Child Labor Branch, Wage and Hour and Public Contracts Divisions, U. S. Department of Labor.

• CALENDAR

July 18–24—First Inter-American Conference on Rehabilitation of the Crippled and Disabled. Mexico City, Mexico. Sponsored by the International Society for the Welfare of Cripples, in cooperation with the Mexican Government.

Aug. 11–13—International Association of Governmental Labor Officials. Charleston, W. Va.

Aug. 12–21—International Congress on Mental Health. London, England.

Aug. 23–27—International Congress on Population and World Resources in Relation to the Family. Cheltenham, England. Auspices of Family Relations Group of Great Britain.

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TOWARD WORLD UNDERSTANDING

As this issue of *The Child* reaches our readers, an international commission is in London, analyzing some 300 studies of human relations, studies made during the course of the past year or so in countries all over the world.

All this is in preparation for the International Congress on Mental Health, which will meet at London in August.

The congress believes, with UNESCO, that "since wars begin in the minds of men it is in the minds of men that the defenses of peace must be constructed."

For though understanding is no guaranty of peace, there can be no lasting peace until there is understanding.

In accordance with this idea, the studies, made by small groups meeting informally, are planned by the congress as steps toward a world effort for better understanding among peoples.

The congress comprises three conferences, two of which are on technical psychiatric problems. The third, the International Conference on Mental Hygiene, is not a meeting for psychiatrists only, but for all types of professional workers interested in the social sciences.

Some of those attending will be psychiatrists; others will be anthropologists, sociologists, clergymen. Educators, including nursery-school teachers, will be there; also pediatricians and general medical practitioners; as well as nurses, social workers, and many others. The work of this conference will be based on the reports and recommendations from the small groups, or preparatory commissions.

Like the conference itself, these small groups are made up of representatives of different professions interested in the social sciences. Many readers of *The Child*—professional workers in some field concerned with children—are members of one or another of these groups.

The preparatory commissions all over the world have reported on subjects covering a wide range, but all converge on one central idea. This idea is that human beings can learn to get along with one another—in the family, in the industrial establishment, in the nation, and in the world.

Many of the preparatory commissions did not go out of existence after sending their reports to London. They found their discussions so stimulating and valuable that they are continuing to meet. Some of them will undoubtedly contribute valuable material to the planning for the Midcentury White House Conference, to be held in 1950.

Dedicated to the proposition that peoples *can* live together in peace, the International Congress will work toward what Brock Chisholm calls "the planned development of a new kind of human being, who can live at peace with himself and his fellow men."

Dr. Chisholm believes that this can be done "if, at the International Congress on Mental Health, even a few principles of mental health, even a few signposts for the bringing up of children, even a little hope for a sorely beset and anxious world can be agreed on by qualified people from all over the world."

Katharine F. Lenroot

Chief, Children's Bureau

VOL. 13 No. 1 JULY 1948

the CHILD

published monthly by the
Division of Reports
CHILDREN'S BUREAU
Managing Editor Sarah L. Doran
Art Editor Philip Bonn

FEDERAL SECURITY AGENCY
SOCIAL SECURITY ADMINISTRATION

CHILDREN'S BUREAU
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Publication of THE CHILD, monthly bulletin, was authorized by the Bureau of the Budget, May 12, 1936, to meet the needs of agencies working with or for children. The Children's Bureau does not necessarily assume responsibility for the statements or opinions of contributors not connected with the Bureau. THE CHILD is sent free, on request, to public officials and libraries. For others, the subscription price is $1 a year. Send remittance to the Superintendent of Documents, Government Printing Office, Washington 25, D. C., foreign postage, 25 cents additional. Single copies, 10 cents.

U. S. GOVERNMENT PRINTING OFFICE: 1948

AUGUST • 1948

the CHILD

LEARNING TO LIVE TOGETHER

New Haven experiment in neighborliness

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THE Day family of New Haven, Conn., packed their belongings and joined the wartime migrant families of the country in 1942, when Dr. Harry Luther Day was commissioned in the Army.

In the next 2 years they traveled from one airfield to another, through 14 States. But they traveled a far greater distance than actual miles, over a long, long road from their secure New England moorings back to raw, primitive prejudices and discriminations exposed in the churning populations of war-born communities.

Mrs. Day and the children found themselves migrants, among the 6,000,000 other migrants created by war, living in unsavory quarters because there was no other place to be found, in crowded housing projects, or trailer camps. This New Haven family was one small fragment of America—America in the crucible of change, becoming aware of some of its own weaknesses and searching for new strengths.

When, in 1944, her husband was sent overseas, Mrs. Day and her three children came back to their home in New Haven.

Gertrude Hart Day looked about her at her own neighborhood, her own community, with a fresh eye of observation. At her very doorstep could be found many of the tangled problems to which she and her children had been exposed. People within a stone's throw were subjected to prejudice and intolerance because they were "different."

If changes were to take place, Mrs. Day felt, the logical starting point was right in her own neighborhood. Earlier experience as a social worker stood her in good stead. She sought out others, in the parent-teacher association to which she belonged, in the churches—wherever groups were to be found—and invited them to talk things over. At first only a handful came, meeting in one another's homes. As they considered some of the things they might do together as a neighborhood group, barriers of racial and religious differences gradually disappeared, particularly as the group centered upon what they could do for children.

How the project grew

The first need was for a playground—there was little space for the children to play after school. The neighborhood group found a yard that had once been a playground, pooled their resources and got the cooperation of the board of education in equipping it for use.

The informal group then became a neighborhood council. They moved from filling one simple need, upon which all agreed, to another. The next thing was a nursery school, which they called the Neighborhood Nursery School. They organized it on an interracial basis. The equipment and setting were simple; the school set up in a family home.

But from the beginning the educational standards were high. The staff was carefully chosen, with advice from the Clinic of Child Development of the Yale University School of Medicine and from the New Haven State Teachers College. It was a good nursery school and has continued on the highest educational level.

From that small beginning, within a single neighborhood, gradually has developed what is known as the New Haven Neighborhood Project. It has taken that name because all its activities are carried out on a neighborhood basis (a neighborhood being recognized as a grouping of some 1,800 persons living within natural boundaries). The project now includes three nursery schools (a fourth is to be opened in the fall, and a fifth is in prospect); a summer play school for older children; a book project, with reading and study groups; and three neighborhood councils sponsoring a variety of activities.

It has become a significant experiment in building understanding among people of different races and faiths and breaking down prejudice, with children as the starting point. After about a year and a half the experiment was taken under the sponsorship of the National Conference of Christians and Jews.

The project is a try-out of democracy at the level of the neighborhood and the community. While its basic motivation is building fellowship and tolerance among people of different races, this emphasis is never deliberately imposed. The children lose sight of the fact that a favorite playmate's skin is dark. He rates because he can build a good block house or tell exciting stories. Contact in normal situations brings understanding.

In the summer play school last year 80 children swam and hiked and played together. They represented 16 different nationality backgrounds: three races, white, Negro, and Asiatic; and the three major religious faiths in this country. Many of the white children never before had come face to face with Negro children of their own economic background; 80 percent of them never had mingled and played with them. The Christian and Jewish children, although meeting in school, had rarely mingled outside of it. But they forgot, as they had fun together, that skins were white or black or yellow, or religious faiths different.

Not only are the roots of this community experiment deeply embedded in the neighborhood, but in most of the activi-

Children are a starting point toward understanding among people of various races and faiths.

ties the atmosphere remains that of home and family. The executive headquarters, as well as the largest of the nursery schools, the Neighborhood Nursery School, are in the Day family home. Mrs. Gertrude Hart Day is director of the project. The house is an appropriate setting. It has the flavor of New England—it is rambling and vine-covered, with wide lawns shaded with old elms and great copper beeches. Inside, it is filled with things long lived with. The friendly living room with its book-lined walls is the kind of room in which you might expect to see a family like the Alcotts, Jo and Amy and Beth sprawling before the fireplace. It was, in fact, built by a writer, Ik Marvel, author of "Reveries of a Bachelor," popular a half century ago.

Whole family takes part

The nursery school is found to be a logical core of all the other activities of the project. First, because it interests all ages. Big brothers and sisters in junior high school make toys and paint furniture for use in the school. Parents meet in the nursery school and learn to know each other. Meeting together as parents to compare their mutual problems, studying together or working together, mending broken toys or painting battered furniture, differences disappear. People find themselves knit together around common needs.

More, in fact, has been done for the parents than for the children in this New Haven experiment. Children have a way of accepting each other. With them it is a matter of building a better tomorrow of tolerance and understanding.

The nursery school itself is an educational laboratory. Not only do children of different racial groups attend, but exceptional children are included so that their problems may be studied and mothers helped to bring about adjustments. It is hoped to expand this work if funds can be secured for the special staff required.

The supervisor of all the nursery schools is a capable Jewish mother, deeply interested in the project from the outset. One of the staff members of the Neighborhood Nursery School is a Negro, a gifted musician, well-trained for teaching, and with a rare understanding of children.

The other two nursery schools are in quite different settings and sections of the city; this has definite advantages for the experimental purposes of the project. One is in a housing project, Farnum Courts, in a neighborhood of mixed racial groups. The other, Summerfield Nursery School, is in a church-owned building in a modest neighborhood. It belongs to the people in a very special way. The young people of the church mended and painted the furniture and equipment. The men painted the walls and the women made curtains and provided some of the equipment. Local merchants donated rugs and other furnishings. While both these schools have simple settings and equipment, the supervisory and teaching staffs are of the same high grade as in the Neighborhood Nursery School.

In the fall a new venture, it is hoped, will be a nursery school in a public school. The principal has invited the experiment and the school authorities are carefully considering it. If undertaken it will represent pioneering in a fresh field, and if it proves practical and successful may make educational history in New Haven and the State. The project members have their hopes high.

There is a move to start a fifth nursery school in—a fire house! That would truly be an adventure. Going to school under the same roof with real-for-sure fire engines and firemen heroes would make any 3- or 4-year-old the envy of his peers.

The nursery schools are open 3 days a week. A day at home between school days is looked upon as having definite advantages, and it meets the objections of those who feel that young children should not be too much away from parental care.

Each of the nursery schools is related to a whole pattern of neighborhood situations and, even more broadly, intermeshes with community situations. The New Haven project schools are fortunate in having the resources of the Clinic of Child Development of the Yale University School of Medicine, the pediatrics department of the same school, and the Department of Education of Yale. When personnel are considered, guidance is sought from these sources, and they are continually drawn upon for consultation.

Close relationship also is maintained with the New Haven State Teachers College and the local council of social agencies, the appropriate agencies being appealed to when problems in their

fields are revealed in either the nursery schools or the neighborhood councils. Referrals of mothers whose children need nursery-school service are often made to the project schools by the council of social agencies.

An over-all intergroup neighborhood council, working closely with the National Conference of Christians and Jews, serves as the policy-making, program-planning, fund-raising body of the project. The council operates through a series of subcommittees dealing with such subjects as tension situations, program resources, study groups, literature, and fellowship activities.

Two simple principles have guided the leaders of the New Haven project at every step. One is: "Start slowly, and build upon genuine interest"; the other, "Don't start anything unless enough people are interested to carry it through." Interest may be expressed by nothing more than the contribution of a book or of a few hours of time, and still be real.

From this kind of neighborhood-rooted interest have grown a number of activities, all having the same underlying motive of building better human relations. One of these is the United Through Books project. This has developed because some of the members of neighborhood councils felt a need to attack ignorance and intolerance through knowledge. A collection of books has been made on interfaith and interracial topics. The exhibit library is set up before meetings of various organizations such as parent-teacher meetings and veterans groups, and provides material for home-study and discussion groups.

The summer play school is one of the happiest activities carried out under the auspices of the project. This takes in children from 5 to 12 years, divided into two groups. The children bring a picnic lunch and spend the day under the guidance of trained leaders, with mothers helping as volunteers. Hikes, excursions, water sports, story telling, and dramatics fill the hours. Headquarters again is the Day home, its spacious lawns and nearby woods offering shady spots to play and ample room to explore.

Learning to know one another

The play school, too, is a laboratory of adventure and exploration in human relationships. It offers an opportunity for children to find out about one another. A story hour, for instance, may be taken over by a Chinese mother who tells the children stories of China. A Polish or a Negro mother may sing the songs of her people.

Recently it was realized that grandfathers, often neglected, have something to add to the understanding of children. One grandfather, who had been a woolen manufacturer before he retired, was invited to tell a story of how cloth was manufactured in an earlier time. He constructed a miniature loom, which he used to illustrate his story. Thus grandpa became a person of new importance to the youngsters, and a bond between the old and the young was established.

One visiting the New Haven project naturally asks:

"What kind of difficulties have you met and how do you overcome them?" For of course, in any effort to bring people of different races together you must expect difficulties.

"The way we have gone about this," says the director of the project, "has been to start on a small scale, getting the endorsement of a few key people who will give moral support. We try to anticipate difficulties and find a way around them and we are content to go slowly. We find it takes about a year for a sound project to mature into action."

Although the New Haven project receives a subsidy of $5,000 a year from the National Conference of Christians and Jews for the 2 years the sponsorship lasts, money is also secured from local sources. This year the funds amounted to $7,500. Individual memberships in the project bring in $1,000. Fees paid to the nursery school, varying for the different schools, the price being set by the parents themselves, also bring in some revenue. Various local organizations find ways to raise money. The American Veterans Committee, for instance, through a newspaper drive and other means, raised $1,000.

Closing the nursery-school season this year, a carnival was held to raise funds. More than a hundred persons worked like beavers in the preparation. It proved a spectacular success, brought out more than 1,200 parents and children, was packed with fun, and netted $600. It was unanimously agreed to make the carnival an annual affair.

Not long ago a real-estate dealer in the vicinity of one of the project's centers, who had long held out against sales or rentals to members of one of the minority groups, sold a house to a family in such a group. Asked why he changed his policy he answered: "No use hanging on to that attitude with a place like this in the neighborhood."

The project serves as a kind of visual aid in the community. In several neighborhoods where activities are carried on, institutions have changed their policy and opened their doors to those who

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Story hour is a lot of fun at the summer play school of New Haven's neighborhood project.

In Birmingham, England, this type of bassinet is used for premature babies. It has a washable lining, with three pockets for hot-water bottles, one at each side and one at the foot.

BRITISH EXPERIENCE IN THE CARE OF THE PREMATURE BABY

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ENGLAND'S first hospital unit for babies born prematurely in their own homes was opened 17 years ago in the City of Birmingham Maternity Hospitals.

For the first 13 years after that, provision in the country as a whole of such special accommodation for premature babies increased slowly.

But in 1944, the Ministry of Health issued a circular to all welfare authorities, recommending that they provide facilities for care of premature babies, both in hospitals and in their own homes, and this circular has stimulated a great deal of interest in such babies.

Most welfare authorities have carried out the Ministry's recommendations concerning home care, but lack of building facilities has held up many programs. Efforts have been made, however, to set up units in existing hospitals, such as the unit described in this paper.

The need for special care of premature babies is as great in Britain as it is in the United States. In Birmingham, England, 6 percent of all the babies born alive are prematurely born (that is, they weigh 5½ pounds or less at birth).

Prematurity accounts for approximately three-fifths of the deaths of infants during their first 4 weeks of life, and one-third of the deaths up to the end of the first year.

The Ministry of Health circular suggests that for every infant weighing 5½ pounds or less at birth the weight should be recorded on his birth-notification card, and as a result country-wide figures for the incidence and mortality of premature babies will soon be available.

What causes prematurity?

Various investigations have been carried out recently in Britain in order to discover the causes of the premature births. These are most conveniently divided into known and unknown causes.

Known causes.—In different investigations, maternal ill-health was reported for 32 to 48 percent of the premature babies, toxemia being the greatest single cause of prematurity. It was found that in 12 to 16 percent of the cases the pregnancy was multiple. Fetal deformity occurred in 3.4 to 5.9 percent of the premature babies studied.

Unknown causes.—In the previously mentioned investigations no cause for the onset of premature labor was determined in 32 to 51 percent of the cases.

More attention is now being given to the effect of social conditions on prematurity; and Prof. Dugald Baird has demonstrated three important facts concerning premature infants born in Aberdeen:

(1) The incidence of prematurity is twice as high among the poorer people as among the richer.

(2) Among the poorer people, over 50 percent of the prematurity is unexplained; among the richer, a very small percentage.

(3) Proportionally more of the smaller premature babies are born to the poorer people.

(4) Among the poorer people the premature babies in every weight group have higher mortality than among the richer. In other words, premature babies born of poor mothers have a lower vitality.

An experiment carried out by the Peoples' League of Health showed that an adequate diet during pregnancy can reduce the incidence of prematurity.

What causes death in the premature baby?

Among premature babies in Great Britain the principal causes of death in the first month of life are: (1) Prematurity, (2) intracranial birth injury, (3) infection, and (4) fetal deformity.

In Birmingham, a premature baby is 22 times as likely to die during the first 4 weeks of life as a baby weighing over 5½ pounds at birth, and the risks of death from infection and from birth injury are each nine times as great for prematures as for other babies.

The risk of death between the ages of 4 weeks and 1 year is approximately twice as great for premature babies as for other babies, and it is interesting to find that the increased risk of death from infection still exists after the first 4 weeks of life; it is more than twice that for babies that are not premature.

How can we reduce mortality due to prematurity?

As steps toward reducing the high mortality due to prematurity, efforts are now being made to reduce the incidence of premature birth by improving social conditions, ensuring an adequate diet during pregnancy, improving prenatal care, and providing more hospital beds for pregnant women with complications likely to lead to premature labor.

In addition, efforts are being made to reduce the mortality among premature babies by ensuring better care for them during and after delivery.

A program including all these efforts has been in effect in Birmingham for a number of years, and the deaths among all premature babies in the city during the first 4 weeks of life were reduced from 26 percent in 1938 to 18 percent in 1946; the deaths among such babies in the first year of life were reduced from 34 percent to 23 percent.

These figures can be still further reduced, as is shown by the results obtained in the City of Birmingham Maternity Hospitals, to which the premature-baby unit described in this paper is attached. In 1946 the incidence of prematurity in this hospital was 8.5 percent, and the neonatal mortality among the 188 premature babies born there was 10.1 percent.

When Birmingham's premature-baby unit was opened, in 1931, it consisted of one large nursery for 10 infants and 6 single rooms for mothers. It soon became obvious that smaller nurseries, and more of them, were required.

Thereupon the large nursery was divided into two smaller nurseries, and some of the single rooms were also used as nurseries. This, however, limited the accommodation for mothers and therefore lowered the incidence of breast feeding.

Recently it was decided to take over the second floor of the building, and the unit will now accommodate 26 babies and 8 mothers.

The first floor consists of two warm nurseries, four cool nurseries, two isolation nurseries, a milk room, a ward kitchen, utility rooms, and a nurses' toilet.

The second floor consists of eight small wards (each for one mother and baby), a demonstration room, a day room for the mothers, a ward kitchen, a utility room, a bedpan room, and a bath and toilet for the mothers.

All nurseries are entered from a central corridor, where the nurses and doctors put on masks and gowns and wash their hands.

Traffic into the nurseries is strictly controlled. The only persons who enter are the nurse on duty in each nursery, the nursing superintendent of the unit, the senior medical officer, and the pediatric resident physician. Visiting doctors, nurses, medical students, and so forth, are only allowed to observe the nurseries from the corridor.

The smallest infants, requiring the most individual care, are placed in a nursery with four bassinets, as four is believed to be the maximum number of such infants that can be cared for by one nurse per shift.

The somewhat larger infants (under 4½ pounds, but not requiring so much individual care as the smallest ones) are placed in a nursery with six bassinets, as one nurse per shift is able to care for this number.

As there are no cubicles in these nurseries, a floor area of 50 square feet is allowed for each bassinet, and the bassinets are placed 6 feet apart. This arrangement has proved most successful in preventing spread of droplet infection from one baby to another.

The two warm nurseries are kept at a temperature of 70° to 75° F. Higher temperatures are avoided because of the bad effect on the staff. (English doctors and nurses are not accustomed to the high temperatures commonly found in America.)

Luckily, experience has shown that even the smallest babies thrive well in a nursery kept at this temperature, provided the bassinets are heated. The nursery temperature becomes detrimental to the smaller babies only when it falls below 70° F. We have found that babies over 4½ pounds usually do better in a temperature of 65° F. after the first few days of life.

Each of the four cool nurseries on the first floor accommodates two bassinets. These nurseries are kept at 60° to 65° F., according to the need of the infants. Two isolation nurseries accommodate two cots each, and these nurseries can be kept at any temperature or humidity desired.

The eight wards on the second floor are kept at 60° to 65° F. A baby is only transferred to his mother's room when he is sufficiently well developed to cope with the relatively cool atmosphere and when he is able to feed from the mother's breast.

The provision of accommodation for breast-feeding mothers has proved an important factor in promotion of breast feeding.

Heating the nurseries

All nurseries are heated by hot-water radiators and gas fires. Natural means of ventilation are used (windows and ventilators) and the required humidity is obtained by heating pans of water on gas rings.

The relative humidity in the warm nurseries is 60 to 65 percent; it is measured by wet- and dry-bulb thermometers provided in each nursery.

No air-conditioning plant has been installed because the unit is a training school for nurses who will go into homes to care for premature babies, and it is important to teach these nurses how to obtain the necessary conditions by simple means available in an ordinary English home.

Each nursery has a lavatory for hand washing, a diaper can with a lid, and a receptacle for soiled linen.

Each bassinet has a locker containing toilet articles and a thermometer, also a shelf for the nurse's gown.

The milk room is equipped for sterilization of bottles and preparation and sterilization of breast milk and milk mixtures. Nurses enter this room only if they are wearing cap, gown, and mask.

The kitchen on the first floor is chiefly for the use of the staff, but it is also available for washing used bottles and nipples, so as to avoid taking soiled utensils into the clean milk room. The kitchen on the second floor is for the use of the mothers.

A large utility room on the first floor contains a small electric sterilizer for instruments, small bowls, and receivers, and a large sterilizer for the bathing bowls. (Bathing bowls are used for the larger and older infants, to avoid the use of common baths.) A smaller utility room on the same floor is used for collection of diaper cans until they are removed from the unit. A utility room on the second floor is used for sterilizing.

A day room is provided for mothers who are up and about. A mother is accepted for admission when her infant is 3 days old, after the period of greatest mortality is over and the infant is likely to survive.

Mothers usually remain in the unit for 3 weeks; they then return home and come to the hospital daily to supply breast milk. As soon as the baby is strong enough to suck, the mother breast-feeds him once a day.

A demonstration room is provided for the use of mothers who are living at home and coming to the unit each day for the purpose of breast feeding. In addition, this room is used to teach mothers how to care for their babies before the babies are sent home.

Babies are brought to the unit by the city ambulance service, in special baskets, each heated by three hot-water bottles. These baskets are kept at the ambulance station.

Each time an infant is brought to the unit in one of these baskets, a clean basket is handed to the ambulance nurse in exchange, thus ensuring a supply of clean baskets at the ambulance station.

The ambulance nurse is provided with a flashlight so that she can watch the baby's color. A mucus catheter is available, and also a supply of oxygen, which is given by means of a rubber mask.

On arrival at the unit, the baby is admitted to a warm nursery, if newly born and free from exposure to infection. If he is admitted later than a few hours after birth, or if he has been exposed to infection, the baby is placed in an isolation nursery until proved to be free from infection.

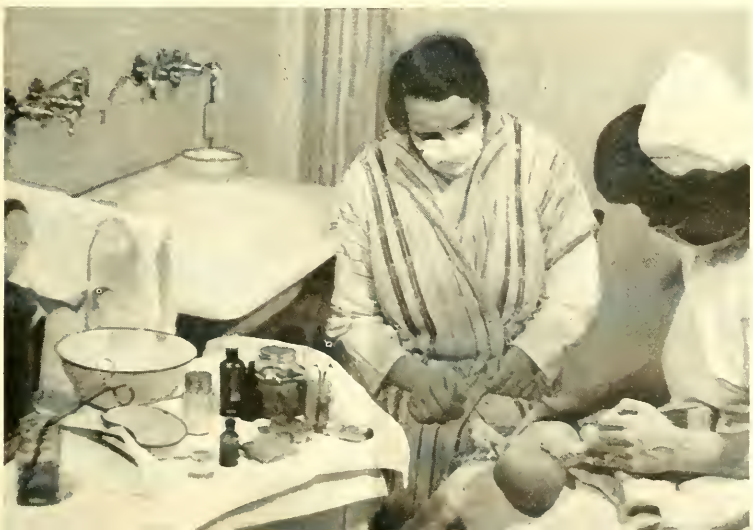
On admission, the baby's general condition is noted, his rectal temperature taken, and the cord inspected for bleeding. The infant is then transferred to a heated bassinet and allowed to remain undisturbed (except for emergency treatment, such as suction to remove mucus from his throat, or administration of oxygen) until he has recovered from his journey. Weighing and dressing are delayed until the condition of the child warrants the handling involved.

The resident physician examines each baby for signs of abnormality or disease as soon as possible after admission. During this examination, the child remains in the bassinet and is handled and exposed as little as possible. Vitamin K (2 milligrams) is given routinely to each baby.

Up to the present time no incubators have been used. Open bassinets, with three hot-water bottles, are used for even the smaller infants. Each bassinet is fitted with a washable lining, in which there are three pockets, for hot-water bottles, one at each side and one at the foot.

For a small baby, additional heat is supplied by means of an electric pad placed under him. To prevent contamination of the pad, or electric shock, or overheating of the baby, the pad is covered by two layers of rubber sheeting, separated by four layers of blanket. The hot-water bottles are changed, in rotation, every hour, in order to keep the heat of the bassinet as uniform as possible.

This mother in Birmingham, England, is being taught by a nurse in the maternity hospital how to take care of her premature baby. Before the baby is discharged from the hospital, a public-health nurse will visit the family home to be sure that everything is ready to receive him.



Thermometers inspected regularly

Each heated bassinet is provided with a thermometer, which is placed between the blankets on top of the baby. This thermometer should never rise above 95° F. if overheating is to be avoided. Each electric pad is provided with a red "telltale" light, which reminds the nurse at regular intervals to inspect the thermometer.

The baby's clothing is made of "union flannel" (wool with a small percentage of cotton to prevent shrinkage). A set of clothing consists of a vest, a hooded gown, a diaper, and a bib. As the air in the nurseries is relatively cool, the baby's loss of heat from his head may be considerable unless the head is covered, and, for very small babies, head shawls are used in addition to the hooded gowns.

In the rather cool English nurseries, it is important to avoid unnecessary exposure during such nursery procedures as changing the diaper or the clothes, oiling, and temperature taking. The smaller babies are cleaned with oil. A soap-and-water bath is not given until a weight of 4 pounds is reached.

In healthy babies, the rectal temperature is taken twice daily and it is allowed to stabilize between 96° F. and 99° F.; the smaller the baby, the lower the level of stabilization within this range.

The baby is kept lying on his side (on the right side after feedings and on the left side between times) because of the danger of his regurgitating food and inhaling it. The smaller the baby, the less he is handled; and any necessary handling takes place before a feeding, not after.

Oxygen is given by means of a soft rubber face mask. Nasal catheters are avoided because of the danger of injury to the baby's nasal membrane and the possibility of subsequent infection.

Feedings are started after 12 to 24

hours of life. At first small amounts are given; these are gradually increased until, at the age of 7 days, the baby is receiving daily 2 ounces per pound of body weight, and at 14 days, 3 ounces per pound of body weight. At this latter time the daily caloric value of the food is usually 50 to 60 per pound of body weight.

Breast milk is used whenever possible, the protein content being increased by the addition of 1-percent or 2-percent hydrolyzed casein. If breast milk is not available, evaporated milk is used, in increasing strengths from 1 to 12 to 1 to 5, with 1-percent or 2-percent added hydrolyzed casein and added sugar.

Babies not strong enough to be put to the breast are fed by bottle if they can suck well. A medicine dropper is used if the baby sucks poorly but can swallow, and for babies with poor swallowing ability feedings are given by stomach tube. The baby is fed every 2 hours until he can take a sufficient amount at each feeding to be fed only every 3 hours.

Administration of vitamins B and C is commenced on the third day, and of A and D on the seventh day. A preparation containing calcium and phosphorus is started on the fourteenth day because of the low mineral content of breast milk and the relatively great requirements of the premature baby. Administration of iron is begun at 4 to 6 weeks.

To prevent infection

Measures for prevention of infection, such as limiting the number of bassinets in each nursery, spacing of bassinets, free ventilation, and limitation of traffic into the nursery, have already been mentioned.

Parents are allowed to see their babies from the corridor through viewing windows. Other relatives and friends are not allowed to visit.

The members of the staff are medically examined before being allowed to take up duty in the unit and must report if sick.

Absorbent and impervious masks are used by everyone working in the unit, including the mothers when feeding or caring for their infants and the workers who clean the floors of the nurseries.

Floors are treated with oil to reduce the risk of dust-borne infection.

Direct infection is prevented by the use of gowns, by careful hand washing, by care with laundry and in preparation of feedings, and by providing individual equipment for each baby. Bedside care has replaced the use of common changing tables, and sterilized bowls have replaced the common bath. All pieces of necessary common equipment, such as stethoscopes and measuring tapes, are carefully sterilized before use, and weighing scales are draped with a fresh piece of paper for each baby.

Any baby showing the slightest sign of infection is immediately removed to an isolation nursery, and no new baby is admitted to the affected nursery until the nursery has been proved free from infection.

The nurse responsible for preparation of feedings is never allowed to undertake duties that involve changing of diapers. With this one exception "task-nursing" is not favored; in fact, one nurse is responsible for the complete care of all babies in her nursery, and she does not enter other nurseries.

The senior medical officer in charge of the unit visits it twice weekly, seeing each baby and discussing current problems, and she is also available day and night for consultation. This medical officer is responsible for the plan of care, which is available in writing for the use of the medical and nursing staff.

In addition, the pediatric resident physician visits the unit daily, examines each infant on admission and before discharge, and is available day and night for emergency calls.

Before a baby is discharged, his home is visited by a public-health nurse, to ensure that everything is ready for him. In addition, his mother is given demonstrations on the care of her baby (bathing, dressing, handling, preparation and giving of feedings, protection from infection, and so forth) before he is sent home.

Arrangements are made for the baby to be taken to the special "small baby" session at the well-baby clinic, and to return to the unit for special follow-up examinations at stated intervals.

The unit is recognized by the Ministry of Health as a training center for nurses in the care of the premature baby.

Medical students from the University of Birmingham are given demonstrations in the unit and many postgraduate courses for doctors, nurse-midwives, public-health nurses, and so forth, are held at the unit.

Many aspects of prematurity are being studied in the unit; for example, the effects of high-protein feeding, the incidence of rickets, the prevention of anemia, and the rate of mental and physical development of the baby. It is of interest that retrolental fibroplasia has not occurred in the Birmingham premature babies.

Hospital care is obviously best for premature babies with poor homes. It is also best for all those weighing less than 4½ pounds at birth, because these small babies are likely to regurgitate food and inhale it and so require a whole-time nursing service. But results can be very satisfactory for the larger babies treated in good homes with good equipment and a good nurse. In some parts of England no special hospital accommodation is available for premature babies, and home care becomes important.

When the baby goes home

Recommendations in the Ministry of Health circular for home care are:

A separate room for the mother and baby, provision of equipment on loan by the local health authority, a supply of expressed breast milk when necessary, the advice of a pediatrician, and the services of a homemaker to care for the family while the mother is unable to do it herself.

Nurse-midwives and public-health nurses with special training and experience in the care of premature infants are recommended as suitable persons to give attention to premature infants born at home.

The suggested equipment for loan includes a bassinet, clothing, hot-water bottles, an electric pad, a feeding bottle, a thermometer, and a mucus catheter. It is doubtful, however, whether an electric pad should be included, because of its possible dangers, especially from overheating, when in unskilled hands.

In Britain we realize that reduction of mortality due to prematurity can only be achieved if there is full realization of the dangers associated with prematurity and if full cooperation exists between the hospital staff and the home attendants. This entails special education of the various persons concerned.

Reprints available in about 3 weeks

WE NEED FACTS IN PSYCHIATRY

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IN this looking forward which you have asked me as a representative of psychiatry and medical mental hygiene to do, perhaps you have chosen someone with too little faith. I can foresee no immediate fulfillment of the hopes of a yearning world for the miraculous solution of our emotional problems. Psychiatry has probably sold mental hygiene too well and perhaps too early.

Troubled people have grasped eagerly at the chance to see the promised land. Our psychiatric enthusiasm to show them the green pastures has pushed us with the running steps of speculation and theorizing instead of the painstaking plodding of fact-finding and experimental evidence. It may be excusable, if psychiatry has let its enthusiasm run beyond its capacity to produce a promised body of sound facts and effective workable methods.

If I appear to you as a pedestrian instead of a winged fleet-footed Mercury, I can only plead the evidence of the history of successful medical progress. Preventive medicine has become possible only when we have learned the causes of disease. The successful treatment of physical disease has only been possible after painstaking and painfully slow research and investigation.

Psychiatry today knows extraordinarily little more about the cause of the major mental diseases than it did 50 years ago. It has produced a wealth of theories, but a paucity of facts.

More knowledge required

The violent debates of the protagonistic psychiatric theorists bespeak their lack of facts. The rest of medicine can show a united front because there are larger areas where investigative research has led to logical, irrefutable knowledge. That united front will come to still the babel of voices when psychiatry has comparable knowledge.

Psychiatry and mental health have only just begun to take the pathway of scientific research and investigation. Here and there one sees the beginnings of the quest for real, basic facts and the desire and willingness to subject theory to experimental investigation.

Looking at our hurried false starts should not blind us to the very significant contribution which psychiatry and the mental-health movement have made in this period of their enthusiastic infancy. They have brilliantly centered interest on the study of personality and personality structure.

Although the psychopathology of mental disease is only hypothetically understood, the study of its manifestations have brought into the focus of attention many phases of normal psychology which were dimly lighted before.

Light from different sources

Our studies of the abnormal mind have made possible a dramatic presentation of many facts that must surely have their representation in normal psychology.

We have called upon our young sister sciences of cultural anthropology and sociology to aid us in the proof of this thesis. Furthermore, our hypothesis that psychologic facts do profoundly change personality structure and personality response has been proven for us through investigation by the cultural anthropologists.

Given at the National Conference on Family Life, Washington, D. C., May 6–8, 1948.

I fear that educators and social scientists have been so swept by our promises and our theoretical constructs that they are little more than blind, enthusiastic followers of psychiatrists. Not all try to follow the same theories—there are enthusiastic followers of all psychiatric camps—but they are all trying to put into corrective practice in the normal what the various schools of psychiatry have said was wrong with personality.

Again, like Cassandra, I moan, if only we could guide them with an established body of proven, sound data!

We must, I am convinced, undertake in the near future many long-range, painstaking studies.

We must try to get answers

1. We need investigative research to instruct us whether we are right in thinking that healthy emotional maturity and balance may be achieved by the present fashionable permissive attitudes or whether directive attitudes in education, especially of the emotions and emotional attitudes, will produce the type of emotional balance we need.

2. We must be able to answer with evidence the question whether human psychologic healthy development is governed, as one theory insists, only by the avoidance of so-called anxiety or conflict; or whether according to another theory it takes place by a more vital dynamic emergence of positive and trainable drives and action patterns.

The answers to such questions are vital and at the core of our problem of mental health.

That we can influence personality structure by environmental circumstance is established, but that is far

from knowing when and how it can be altered.

3. We must be able to answer many fundamental questions about the relative importance and influence of early life experience on final personality structure and reaction.

Are we right about the time element?

Perhaps future investigation may show that the later unfolding of latent patterns of behavior may play as decisive a role in personality structure as infancy and early-childhood influences. There is some evidence that this hypothesis of later unfolding may be even more important. This is clearly open to investigation and should be investigated in animals as well as human beings.

4. We need to know if mass cultural impacts on youth, such as those produced by the Nazification of German children are lasting and permanent—or are they modifiable?

5. We need to know whether the similar although not deliberately planned cultural impacts in these United States of increasingly more constricted housing, enlarged cities with more and faster automobiles, more and more out-of-the-home meetings of youth are permanently destructive of family life or whether they are capable of modification and resynthesis.

6. What impact will our expanding of the school period from very early childhood to very late adolescence have upon the family and its importance in the life story of our people? Will this strengthen or weaken the home and family?

7. Is the purpose of our present emphasis on the importance of love and security attainable in a system where less and less of the education and recreation of children and young people takes place within the family structure? Can we substitute qualitative for quantitative participation in family living and still maintain the valuable influences of the family? If so, how can we develop techniques for this new kind of concentrated family influence?

8. Will mental health be increased or decreased by decreasing or increasing the family strength? Again I say, we do not know. Cold, hard facts and investigation alone can give the answers.

Of one thing we can be certain. The ignorance of blind conviction or even noble prejudices will not give the answers. Psychiatry as such will always of necessity be concerned primarily with psychopathology. The study of disease can point the way to the study of health, but ultimately it will be the study of normal growth and development that will produce the techniques for healthy living.

I believe that an experimental sociology, an experimental, cultural anthropology, and an experimental individual psychology offer most of our hopes for the future of the development of mental health.

Psychiatry, with its study of the abnormal, will be an increasingly valuable helper, a stimulator, and a corrector. It must develop positive, factual, and experimental investigation to fortify itself in the scientific investigation and interest in human mental health which it has started.

Psychiatry is started in its scientific, investigative attitude but it can only do its rightful job if the Nation furnishes it with facilities for investigation and enough money to attract a growing group of young investigators.

Mental health calls for wider extension of counseling services in schools and in the community.

What can we do at once?

As I see it, the *immediate* contributions that mental hygiene can offer are:

1. Increasing use of group discussions for parents and children. It has high hope of objectifying tensions and problems.

2. Increasing use of sex education—for facts and attitudes.

3. Training of youth for parenthood by practical, thorough courses in child training, with the use of actual nursery schools in high schools.

4. Wide extension of counseling services in schools and in the community.

5. Public discussion by radio, magazines, newspapers, and group discussions, as well as school education, to try to break up paranoid belief systems—political, social, economic—which so disrupt our community solidarity.

6. Frank facing of the possibilities of war and the use of training for both possibilities—peace and war.

7. Extension of mental-hygiene clinic facilities to all areas of these United States, to aid in diagnosis and prescription for treatment; to make evident the need for more facilities for better special education and techniques; and the great extension of boarding-home facilities—to salvage children when the home has failed.

Reprints available in about 3 weeks

UPHOLD RIGHTS OF PARENT AND CHILD

INEZ M. BAKER, Parish Supervisor, Children's Division, Orleans Parish Department of Public Welfare, Louisiana

PARENTS and children should, of course, have the opportunity to remain together if they have the *will* and a reasonable possibility to do so. However, as long as society is subject to its present ills, some children will have to be cared for by other than their natural parents, and children's agencies will try to place them in foster care—in a family home or in one of the many forms of group or institutional care.

The type of placement determines in some measure what rights and responsibilities the parent retains or relinquishes when separated from the child. The very nature of placement service is such that the rights of the individuals affected can easily be violated unless the agency that provides the service, as well as the citizens who support it, are aware both of the nature of separation and placement and the rights that may be threatened.

Let us first look at the purpose of the children's agency. It has no legal authority, unless the law specifically grants this. The agency's purpose is to serve individuals—parents and children.

It is parents who first come to the agency, hoping that solution of their problem lies in placement of the children. The problem may result from illegitimate pregnancy, physical or mental illness of one parent, desertion, separation, or other conditions. More often than not it mirrors a combination of subtle and complicated factors—marital difficulty, rejection of children, immaturity of parents, and inability to accept parental responsibilities.

Whatever impels a parent to seek placement of his children, he has a right to know what placement will mean to him and his children. The agency has a responsibility to help him consider what both must give up, as well as what both may gain.

And indeed any parent who places a child does give up a great deal. He cannot see to the child's day-by-day care and all that goes into it. He has no control of the child's activities, his friendships, or the affectional ties that may develop. He must comply with rules on visiting and on payments for board, and he is limited regarding the gifts and recreation he may provide. Such deprivations are inherent in separation and successful placement.

Then there are rights that a parent must not be denied except by a court of proper jurisdiction—the right to see his child, to provide financial support, and to terminate the placement when he sees fit.

Many questions arise

Besides these tangible matters, there are subtle ones, even more serious. Does the parent know how he will feel about having his children cared for by someone else? Does he feel that in placing his children he advertises to the world his failure as a parent? What about his feeling of worthlessness? Does he know that his children may on the one hand despise him for what he has done, and on the other feel that they are "bad" and unworthy of the love of even their own parents? Does he know that his children may resist foster care in unspoken ways, ranging from wetting the bed to stealing? Is he prepared to work with the agency down the long and rocky road to happy, successful placement?

Parents and children have a right to know what is involved. They have a right to expect help and understanding in thinking through their conflicts about this all-important decision, just as they have a right to expect help in supporting the child in foster care if this is decided upon.

Condensed from paper given at Louisiana State Conference of Social Welfare, Baton Rouge, March 1948.

Furthermore, the agency can fulfill its purpose of serving parents and children only if it recognizes the right of the parent to decide whether or not placement is a desirable solution to his problem. This means that the parent makes his decision to place or not to place, without pressure, threats, or persuasion by the worker. So long as the parent has full custody of his child, the decision rests with him, not with the agency. He has a right to decide what is best for him and his children unless the right is legally denied him. In a democracy that right can be denied only by a court of competent jurisdiction.

Yet parents are sometimes denied the opportunity to make this decision. We social workers sometimes stress the advantage of placement, hoping that we can keep the parent satisfied with an arrangement he does not understand and which is not really his. It is beside the point to say that such placements are doomed to failure.

We must not deny parental rights

To assume that we know best is to take liberties with the complicated relationships between children and parents. This not only denies parental rights but is contrary to the agency's duty to provide services that parents are free to utilize or reject so long as their legal authority concerning their children remains intact.

To reiterate, the responsibility for the decision to place or not to place rests with the parent as long as he has his full legal rights concerning his child. The responsibility of the children's agency is to help the parent come to a decision that is right for him and his child and to help him live with his own feelings. This implies acceptance on the part of the agency of the client's decision and his feelings about it. It is very different, and requires more skill

and self-discipline than making a decision for the client according to what the worker may consider desirable. So long as the right to make the decision rests with the parent, the agency must respect that right.

Recognition of the right of parents to make decisions in behalf of their children does not in any way deny the responsibility of the agency. This is to apply case-work skills in helping parents to see what alternatives are open to them and where these alternatives may lead. It is to help the parents recognize, understand, and indeed live with their mixed feelings about caring for or placing their children. This responsibility is also binding on the agency after placement. These responsibilities are important, for few if any parents, regardless of how derelict they may be in their parental roles, are totally without feeling or concern for their children.

So far as we have considered the problem of parents whose legal authority concerning their children is not in question. For these parents, who voluntarily seek help with respect to their children, the agency's part is to provide case-work service, which may include placement if parents and agency agree upon it. When they agree upon a plan for care, the agency must take responsibility for its soundness and success.

This does not mean, however, that the agency passes judgment on plans of which it is not a part. If a parent decides to place a child with Great-aunt Susie, a plan that the worker believes is of questionable value for the child, the worker's role goes no further than to help the parent think through what may be involved in the plan. The agency would not be part of the arrangement with Great-aunt Susie, nor take responsibility for it.

Every client deserves our respect

The fact that a parent brings his problem to an agency does not give the agency authority or license to determine the course of a child's life. So long as parental plans are within the law, the agency has no more right to say where children shall live than to say where they shall go to school, or whether or not they shall have their teeth straightened.

If I labor the point that children's agencies do not have the authority or function to control the lives of children whose parents voluntarily bring their troubles to an agency, it is because of the widespread misconception in this area. Furthermore, if we are clear on the rights of parents who retain full authority over their children, I think we can see more clearly the rights of parents and the responsibility of agencies when a court steps in to alter the natural status of parents and children. Here I should like to consider both families where parental rights are in question and those in which legal action has already restricted or transferred certain parental rights.

Space does not permit full discussion of the so-called "protective" function sometimes assumed by children's agencies. In brief, we might say that families affected by this rather undefined function are those in which the right of the parents to retain full responsibility for their children is questioned, at least by some part of the community, though legal action may not have been taken. Perhaps it is with regard to this group more than any other that we see misunderstanding of the rights of parents and children and of the purpose of children's agencies.

For example, there is Mrs. B., who calls up an agency demanding that a worker come and get the J. children next door and place them in an institution or foster home. Her reason may be almost anything, ranging from the children's being left alone without food to their pulling up the plants Mrs. B. has just set out. The important thing is that Mrs. B. disapproves of the way the J. children are being reared; she thinks they can never become "decent citizens," so there must be "a law against it." The children's agency, for which she pays taxes, or to which she contributes through the Community Chest, must have authority to enforce *her* will to do something about the situation.

Then Mrs. S. calls up. She is indignant about the drinking and immoral behavior of Miss W. The agency had placed Miss W.'s baby, born out of wedlock, and Mrs. S. feels that the agency is encouraging immorality by relieving Miss W. of her responsibility. The proper treatment for Miss W., says Mrs. S., is a good jail sentence to teach her a lesson, and close supervision thereafter by the agency to see that she takes care of her child.

The Mrs. B.'s and Mrs. S.'s, however, are usually reasonable people. When they realize what their request involves, they are horrified, for they would not wish to live in a society where parents' rights could be taken away without due process of law.

To the extent that we, as social workers, are clear on the rights of parents, and the purpose of our agencies, we can hope the Mrs. B.'s and the Mrs. S.'s will direct their energies into more productive channels. And let us not forget that Mrs. B. and Mrs. S. are as much our

Parent and child should be together if they have the will and a reasonable possibility of it.

clients when they bring us these problems as if they brought us problems concerning their own children. They have the same right to our respect and understanding about the implications of their requests.

All citizens, and particularly social workers, should have a sense of responsibility for the well-being of all children. We know that there will always be some parents who misuse their parental rights, just as there will always be some individuals who violate the rights of others. And society must protect itself by placing limitations on the individual who is unable to exercise his own rights without violating those of others. In a free society we delegate to the courts the duty of making the decision as to whether certain of an individual's rights shall be limited, or removed, in the broader interests of society. It cannot be different with parental rights.

Public opinion rules

We have in this country some vague idea of a level of care and opportunity for children that should be the minimum, and this is translated into law with varying degrees of definiteness. The level is interpreted differently in different communities, in different economic strata, and in different races. And I suspect that in a given community it represents pretty generally what the majority of the people in that community want.

And so the Mrs. B.'s and Mrs. S.'s have a right to take situations to court when they feel that children are denied what they consider a minimum of opportunity. We should hope that the community could provide services to enable the families in question to meet the minimum needs of their children if they have the desire and ability to do so. We should also hope that the agency that received such complaints would have a sufficiently careful screening process so that the agency will not intrude upon the family's right of privacy without justification. We should further hope there is general understanding throughout our citizenry that children's troubles are not over when a judge orders separation from their parents and that placement is not the answer for all children whose parents have difficulty in caring for them.

When a court of proper jurisdiction decides that parents have violated, or are unable to exercise, their right of care and control over their children, the court may transfer this right to an agency or an individual. This transfer of custody places with the agency the right and responsibility to determine, and provide the child with, a suitable living plan. The parent has a right to know where his child is, to visit him in accordance with established arrangements, and to maintain his relationship with him, unless specifically forbidden by a court. The latter restriction is rarely placed on parents except in spectacular situations where the child or the person caring for him is physically endangered. When a court removes the child from the parent's custody, the latter may not regain it except as restored by the court. However, the parent has the right at any time to request the court to consider the return of custody. The agency has no right to discourage a parent from making this request.

Before considering the agency's responsibility for helping parents and children whose natural status has been altered, it seems fitting that we as social workers examine our own feelings about courts and their authority.

If we, as social workers, recognize the court as the instrument of our society for dealing with misused rights of parents, then we should be able to use it as objectively as any other resource. If we honestly believe the rights of children are threatened, and we have been unsuccessful in helping parents, do we not have a responsibility to bring the matter to a court's attention?

Agency must be fair with parents

It seems to me that as social workers we have too often looked upon the court as a last resort. To use it was to admit failure. I fear we have at times assumed court authority ourselves in insisting that people do as *we* thought they should, by taking advantage of an emergency to place a child ourselves, and all but refusing to return him if we thought the parent might give improper care.

We have talked about losing our relationship with the client if we went to court. It has been my experience that in most such cases there is not much "relationship" to lose. Usually the worker has long since lost any possibility of a constructive relationship through her tenacious efforts to inveigle the parents into placing their child. Hence, by the time she gets to court, her own feelings are involved, and the parents' belief that going to court is a hostile act by the agency is not entirely unjustified.

I've been thinking a good deal during the last few years about courts, as have many other children's workers. I believe children's agencies have come a long way in making more objective use of the courts. But I fear that we still ask the court to agree with us and to force the parent to do what *we* think should be done.

It seems to me that our duty is to place the facts, as we see them, clearly and objectively before the court. To expect a court to accept our statement without also giving the parent an opportunity to do so is to deny the purpose of a court.

And above all, when it becomes our responsibility to bring a matter involving parents and children before a court, let us be fair. Do not parents have a right to know the step we are taking and the reason for it?

I am convinced that only if the worker is clear, first about parental rights, and secondly about her responsibility to her agency and her profession can she avoid the role of prosecuting attorney. When the worker has clarity, objectivity, and conviction about what she does, she can usually transmit her sincerity of purpose to parents; then there is a basis for working together. The parent may be angry and distressed, but a groundwork for respect and trust is laid.

Let me tell you about a mother, Mrs. M., to whom life has dealt heavy responsibilities, but few inner resources with which to meet them. Her children became the victims. A worker tried to help her; but she could take no definite step, either toward changing her situation within the home or planning for the children away from her.

The worker recognized Mrs. M.'s difficulties. She saw that the agency had not been able to give this mother the kind of help that would enable her to care for her children as the community expected them to be cared for. And in such situations it becomes the responsibility of a judge to make the decision.

So the worker reviewed with Mrs. M. what she would tell the judge—stating what the mother's difficulties were, and also what she had been unable to do for her children. Mrs. M.'s response was anger and despair. She would get a lawyer—would the agency have a lawyer?

The worker told her she had a right to have a lawyer if she wished; that it was not necessary in juvenile court, but that some parents find it helpful to have one. If she did not have the money she could ask the court to appoint one. The worker also explained that the agency did not have a lawyer in this kind of situation. And again she explained the basis on which the agency approached the court and the usual procedure in such a hearing, stressing that Mrs. M. would have an opportunity to tell the judge of the situation as she saw it, and that the worker would present it as it seemed to her. It would then be up to the judge. Mrs. M. responded, "I guess you have to do what *you* think is right."

In court Mrs. M. volunteered that she had decided not to ask for a lawyer. The agency had been fair, she added, so she guessed she could trust it. It would have to be up to the judge.

The judge did give custody of Mrs. M.'s children to the agency. However, the agency now has a basis for working with Mrs. M. and her children in a realistic way. Despite her feeling of frustration she has a degree of respect for the agency because it has been fair to her.

And this leads us to consideration of the agency's responsibility when parents' natural rights have been limited or denied by court action. The parent who has lost his legal control still retains certain rights—the right to see his child and maintain his relationship with him; the right to have the situation reconsidered by the court; the right to know he will not lose permanent custody through adoption. Parents and children also have a right to know what is involved in separation and placement, even though a court denies them the right to reject this service. The agency must respect these rights.

Perhaps the agency's most difficult responsibility is in the area of helping the child and the parent to understand what has happened and to handle their feelings about it. No less than in voluntary placement, the worker has a professional responsibility to help them meet their fears, anxiety, and distress. The fact that a court has stepped in does not minimize the agency's responsibility here, but unless the worker herself respects the authority of the court, she cannot fulfill this responsibility.

We must not omit the child's rights in placement. He has a right to a suitable living plan and to assistance in understanding and handling his feelings. In seeing that he is assured of these rights the worker needs to use professional knowledge and skill.

There is no justification for generalities—that the child needs love and affection and we will place him where he can get it, or that any home is better for him than his own. Except in the rarest cases of physical danger we might go so far as to say that *no* home is any better than his own unless he is able to use it. It is our responsibility to help him use it. We have sometimes leaned on sentimental platitudes and indulged in wishful thinking about children's need for emotional security. Scientific knowledge has stripped us of this kind of justification.

We know what separation means to children; that it is akin to death and carries with it anger, disillusionment, despair, and a deep sense of "badness." We know children handle these feelings differently, but that their usual defense is to deny the reality of, or necessity for, placement. Unless we can help the child to accept the necessity for placement, unless we can understand and accept his feelings about it, we can expect little better than an acting out of these feelings, or repression of them.

He will need help in adjusting to the unnatural state of having two mothers. Unless he can recognize his own feelings and get them off his chest, we may expect his energies to be directed toward gaining the love of his own parents, as symbolized by their taking him home. His fantasies will be engaged in an illusion of parental love. When this happens a child cannot put down his roots or benefit from placement. The potentialities for love and security in his new setting are of little consequence, for he is not ready or able to take them.

Our professional knowledge places upon us a responsibility we cannot escape. If a child is denied the right to live with his parents, be it through voluntary action of his parents, or court authority, surely he has a right to our help in handling the problems that separation has created for him.

In conclusion, we reaffirm the right of parents to make decisions in behalf of their children as long as they retain their legal rights.

The courts are the only instruments in our society with the authority to alter these rights. The role of the children's agency is one of service—not of passing judgment or exercising control, except insofar as control is transferred to the agency by voluntary action of the parents or by court authority. Parents and children have a right to the agency's help in understanding and handling their concerns about placement.

Children's agencies will be successful in discharging their responsibility for this help only if they are clear about the rights of parents and children and about the place and use of courts, and are skilled in their use of professional knowledge.

Then and only then can placement achieve its purpose as a service to parents and children.

Reprints available in about 3 weeks

CALENDAR

Aug. 23–27—International Congress on Population and World Resources in Relation to the Family. Cheltenham, England. Auspices of Family Relations Group of Great Britain.

Sept. 1–30—Youth Month. Sponsored by the National Conference on Prevention and Control of Juvenile Delinquency.

Sept. 4–6—American Occupational Therapy Association. New York, N. Y.

Sept. 7–11—American Psychological Association. Boston, Mass.

Sept. 13–17—American Dental Association. Eighty-ninth annual session. Chicago, Ill.

Sept. 13–17—American Association for the Advancement of Science. Centennial meeting. Washington, D. C.

Sept. 14–15—Children's Bureau Advisory Committee for Maternal and Child Health and Crippled Children's Services. Washington, D. C.

Sept. 20–23—American Hospital Association. Fiftieth anniversary convention. Atlantic City, N. J.

New Haven Project

(Continued from page 20)

before had been excluded. One church held a training institute for Sunday School teachers as a means of developing intergroup understanding in the church-school curriculum, with an anthropologist and a leading authority on preschool education taking part. The director of religious education of the National Conference of Christians and Jews, who is a member of the Yale Divinity School faculty, participated.

It would be difficult to measure how widespread are the effects of this cooperative community experiment. There are visible results which can be seen and weighed. From a small seed, planted by an individual in a single neighborhood, has resulted a series of community projects extending widely over the city. The project has attracted attention outside of New Haven, and the director is constantly called upon to explain the project to other communities. The intangible results of changing attitudes are less easy to measure. Many residents of New Haven, not sympathetic at the outset, have had a change of heart. The project has broken ground in a new field, requiring courage as well as sound procedure at every step of the way.

Many people ask: "Could such a project get under way without the personal drive of a Mrs. Day?"

Others who have studied the New Haven experiment answer that there are Mrs. Days to be found in many communities if a search for them is made. It is true that every such project begins with a fire of concern in the heart of an individual or group of persons. But often the fires smoulder and die for lack of the breeze of initiative to set them in action. More and more, however, people are finding ways to unite their concern in cooperative effort. This project in New Haven has proved that the neighborhood is a logical starting point of group activity to build better human relations.

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"Building Today for Tomorrow in Our Neighborhoods," a manual by Gertrude Hart Day, which should be useful to other communities planning similar projects, can be obtained, by mid-September, from the National Conference of Christians and Jews, 381 Fourth Avenue, New York 16, N. Y., at 25 cents a copy.

IN THE NEWS

TO LAUNCH CHILD-SAFETY CAMPAIGN

In the hope of preventing some of the accidents that every year kill more than 20,000 boys and girls, a safety-education campaign will be launched early in September by the Metropolitan Life Insurance Co., with the cooperation of the American Academy of Pediatrics, the National Safety Council, and the Children's Bureau.

The campaign has two main objectives:

The first is to encourage parents, other adults, and older boys and girls responsible for the health and happiness of younger children

(a) to recognize the accident hazards confronting young children:

(b) to provide and maintain safe conditions for children in the home and at play; and

(c) to help children, through example and guidance, to develop safe practices.

The second objective is to encourage public-health, medical, and other interested agencies to give added emphasis to child safety in their own programs.

The slogan of the campaign is "Help Your Child to Safety." This is also the title of a booklet that is to be distributed to families as part of the campaign.

The booklet stresses not only the child's need for safe physical conditions in the home, but also his need to be free from undue worry or tension. "Often," it says, "a child's unhappiness or lack of self-confidence may be the underlying cause of a series of what appear to be simple mishaps. The child who is disturbed and unhappy may express his feelings unthinkingly in the form of hurts and injuries to himself."

Under the heading, "What Are You Doing to Help Your Child to Safety?" it asks the parents:

"Do you make safety a cooperative undertaking in your family?

"Do you have your child examined periodically by a doctor?

"Do you help your child to develop confidence in himself?

"Knowing children are great imitators, do you practice safety yourself at all times?

"Do you give your child sufficient opportunity to develop sound muscular control?

"Do you help your child to learn the correct and therefore safe way of doing things?

"Have you made an inspection of your home recently to discover hazards, and have you taken steps to make your home as safe as possible?"

This campaign is in harmony with recommendations made by the National Health Assembly's maternal and child-health section. This group declared that accident prevention is as much a health problem as is prevention of disease. It also urged that research concerning accidents be undertaken, to make clear the real magnitude of the problem, to show what causes accidents, and to teach people how to prevent the large proportion of accidents that are preventable.

Similar emphasis was placed on child safety by the President of the United States in his Child Health Day Proclamation last year, when he called upon parents to dedicate themselves to the exercise of diligence toward prevention of accidents in the home, so that children may be protected from needless injury and suffering.

Plans of the program of the accident-prevention campaign are being sent to State and local health officers, State medical societies, school officials, nursing organizations, safety councils, and other groups and individuals interested in health.

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Pages 21 and 23, courtesy of the author, V. Mary Crosse, M. D., D. P. H.

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Page 28, Bernard Ravitz for Brooklyn Children's Aid Society.

Nations Join Hands for World Health

"In my country," one of the U.S.S.R. delegates said to me at the closing session of the first World Health Assembly, "we have a proverb that says, 'Two mountains cannot come together, but two men can.'"

Not two men, but several hundred men and women, representing 54 member nations of the World Health Organization, had come together in Geneva, Switzerland.

Their purpose was to hew out a common roadway ahead, along which the world's health workers and its medical resources might carry the hope of better health to the people of the earth.

For more than a month, the delegates had worked together. We had threshed out, and come to agreement on, many difficult questions. We would return, now, to our own countries. But each of us could carry back with us, not only the new road map of the World Health Organization but the lift of spirit that come when people agree to act together on common problems.

Wherever there are people there are health problems. As you sit in an international conference such as this, and hear the recital of these problems, it takes cool and dispassionate judgment to arrive at a decision how an international organization should go about helping people to better health. To health workers, all health problems have an urgency. But budgets have a way of making you balance urgencies against realities.

The World Health Organization has a total budget of $5,000,000 for 1949. Member nations will contribute to this budget on the same basis as they contribute to the budget of the United Nations. The United States meets 39 percent of the expenses of the UN. Our contribution to the WHO in the coming year, by act of Congress, is $1,920,000. On this basis, the WHO anticipates a budget of $5,000,000—the balance being made up by other member nations.

But even $5,000,000 can give a good push to the WHO caravan as it starts its health-bringing pilgrimage to the people who most need its help.

The World Health Assembly mapped out six jobs to which the WHO should give top priority in the year ahead. The first was control of malaria . . . The third and fourth were control of tuberculosis and venereal diseases. The fifth was promotion of better nutrition. The sixth was improvement of environmental sanitation.

No. 2 on this list of priorities was the promotion of maternal and child health.

I single this out not only because it is of special interest to the readers of *The Child*. It is highly significant that the first assembly of this United Nations body should put promotion of the health of mothers and children so high on its "must" list. It is even more significant that the assembly includes the mental and emotional health of children, as well as their physical health. For the first time here is a responsible international government organization that not only declares in its program that "maternal and child health is a problem of primary importance" but implements that declaration with a plan for action.

This development has large implications for maternal and child health and welfare workers in the United States. Probably in no country of the world is as much experimentation and demonstration in the field of maternal and child health now going on as right here in our own country. Through the WHO all of us will have a chance, such as we have never had before, to pass along the benefits of what we have learned from such experiments and demonstrations to the people of less fortunate lands.

Many of you, in line of duty, will be asked some time to help in spreading through the WHO what you know about good care for mothers and children. I hope, when that appeal comes to you, you will count it an opportunity, not just an extra burden.

Martha M. Eliot

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VOL. 13, No. 2 AUGUST 1948

the CHILD

published monthly by the
Division of Reports
CHILDREN'S BUREAU
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Publication of THE CHILD, monthly bulletin, was authorized by the Bureau of the Budget, May 12, 1936, to meet the needs of agencies working with or for children. The Children's Bureau does not necessarily assume responsibility for the statements or opinions of contributors not connected with the Bureau. THE CHILD is sent free, on request, to public officials and libraries. For others, the subscription price is $1 a year. Single copies, 10 cents. Send remittance to the Superintendent of Documents, Government Printing Office, Washington 25, D. C.

U. S. GOVERNMENT PRINTING OFFICE: 1948

SEPTEMBER · 1948

the CHILD

BRITAIN IMPROVES SOCIAL SERVICES TO CHILDREN

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WHEN I speak of social services to children I mean the services which will give every child in the community the maximum opportunity of developing his powers and his personality for his own happiness and for the benefit of society.

It would once have been true to say that these services would be wholly conditioned by the social and economic development of the community in which the child was living. Today we know that that statement must be qualified.

Already it is one of the outstanding characteristics of the troubled, extraordinarily interesting age in which we live, that the developments or the regressions of one country can no longer be regarded as being of purely national interest.

In the field of child care this is especially true. It is a sphere of activity in which the nations of the world admit to a community of interest, so that an exchange of knowledge and experience between them is gradually becoming an accepted feature of international work. When, therefore, I discuss developments in my own country, I know that you will consider them from two points of view—what they mean in terms of social advance in the national sphere, and what, if anything, might be applicable internationally.

It will perhaps sharpen up your perspective of current developments if we consider for a moment the position of children's services in Great Britain before the recent hideous war.

In the sphere of health, we had a full-scale medical and maternity and child-welfare service, though the provision of treatment facilities was by no means fully adequate.

In the sphere of education, school attendance was compulsory for all children between the ages of 5 and 14, and such ancillary social services as existed were rarely staffed by trained workers.

The child-guidance clinics numbered roughly 60 for the whole country, and of these about one-third were to be found within the school medical service. A steady flow of trained psychiatric social workers was coming from our only mental-health training course, at the London School of Economics. You will, I hope, know that it was the Commonwealth Fund in America which provided, in 1927, the first social-service fellowship for training in the United States, when the first of a succession of British social workers was enabled to take the requisite psychiatric training.

The child neglected in his own home had the protection of the Children and Young Persons Act of 1933, but the preventive or constructive action which could be taken under that act was very limited so long as the child remained in the care of his own parents. Great progress has been made in the treatment of children committed to approved schools through the juvenile courts, and the old-fashioned type of "reformatory" has pretty well passed away with that name, which has disappeared from the official vocabulary.

The child who required care away from his own home for any of the reasons with which you are familiar—death, illness or incapacity of parents,

In Great Britain 5 shillings a week is allowed to every family for each child after the first.

Condensed from paper given at the National Conference of Social Work (Child-Welfare Section), held at Atlantic City, N. J., April 17–23, 1948.

The new British law concerning the care of children specifies that in general the preferred method of taking care of a child who is in need of a substitute home is private foster-home care.

desertion, illegitimacy, broken home, and so forth—fell somewhat fortuitously into the hands of the Poor Law authorities or of some voluntary body, and he received an upbringing which was generally of a more or less institutional type.

All children boarded out with foster parents were subject to supervision up to the age of 9, and only those for whom local authorities had direct responsibility were supervised after that age. Within the local government authorities, responsibility for children was divided between the public-assistance, education, and public-health departments, with the result of varying standards, overlapping in some areas, and gaps in others. There was no specific provision for employment of trained social workers, though they were to be found in a few areas—notably in London.

Then came the war years, with their profound dislocation of family life; evacuation from densely populated areas; the impact of city populations and city problems on rural homes and communities; the jolt to the public conscience and to public understanding which this impact gives; and the realization of the need for social workers, for increased maternity and child-welfare facilities, for skilled psychiatric advice.

Thus there came about the beginnings of a movement to employ trained and experienced social workers, both by the central Government Department concerned—the Ministry of Health—and by the local authorities. We remember gratefully the help given at that time by a small band of trained Canadian social workers who came over to work in the evacuation services and helped to stimulate a better understanding of the principles and methods of boarding out.

Toward the close of the war, public opinion was first shocked and then startled into action by a grievous disclosure of neglect, ill-treatment, and subsequent death of a child boarded out through a local authority. As a result, the Care of Children Committee was appointed by the Government to "inquire into existing methods of providing for children who, from loss of parents or from any cause whatever, are deprived of a normal home life with their own parents or relatives; and to consider what further measures should be taken to ensure that these children are brought up under conditions best calculated to compensate them for the lack of parental care."

This committee, which met under the chairmanship of Miss Myra Curtis, issued its final report in September 1946, a social document of great interest and value, containing recommendations of far-reaching importance which are, for the most part, enshrined in the Children Bill, which is now before the Houses of Parliament and likely to become law within the next 2 or 3 months. [The bill became law June 30, 1948.—Ed.]

Without waiting for legislation, one important administrative recommendation of the committee was carried out when central responsibility for the services concerned was vested in one Government Department, namely, the Home Office, the central Department already concerned with juvenile courts and legislation for the protection of children.

The Children Bill is designed to provide fully for the needs of children deprived of a normal home life and to have them in continuing care until the age of 18. To this end it requires that the responsible local authorities, namely, the county councils and county borough councils, should appoint a new *ad hoc* committee to be called a children's committee, which would be charged with the sole duty of caring for such children, and should appoint a children's officer, who, with the assistance of any additional staff required (whom it is also the duty of the authority to appoint) would carry out the work for which the committee is responsible. The children's officer is expected to be a person (usually a woman) of the best qualifications educationally and in child work with administrative experience. This type of appointment, which carries with it a relatively high administrative status, is quite new in our social-work field.

When a parent cannot care for the child

Among the children for whom the bill provides are those who hitherto could be dealt with under the Poor Law, that famous Elizabethan statute, which, with its wide powers and all the historic variations in its interpretation, will come to an end on July 5, 1948.

The wording of the Children Bill makes it clear that destitution will no longer be the sole factor which determines whether or not the local authority has a duty to provide care. The authority must now have regard to any circumstances which make it impossible for a parent or guardian to provide "proper accommodation, maintenance, and upbringing," though its intervention will depend on its being necessary in the interests of the child's welfare. There are safeguards for parental

rights which make it impossible for the local authority to assume responsibility except as a temporary measure, without the consent of the parents if they are available, unless by order of a court.

A further group of children concerned is made up of those who, for reasons of neglect, delinquency, or being beyond control, are committed through the juvenile court to the care of the local authority or are placed in "approved schools" or "remand homes," which you would, I think, describe as temporary detention homes. Under the previous act these functions were discharged by local education authorities, which could refuse to assume responsibility in certain cases. Under the Children Bill the local authority, through its children's committee, is obliged to accept the responsibility imposed on it by the court.

To protect all children who are away from home

The children's committee will also be responsible for the supervision of children placed in foster homes by their parents or guardians and for whom payment is made—a responsibility now to be transferred from the public health authorities, with whom it rested under the Public Health Act of 1936. This provision will now protect all children and not only those under the age of 9.

The children in the care of voluntary societies, whether in children's homes, or boarded out with private foster parents, form the only other large group affected by the bill. Supervision of these children is not vested in the children's committee of the local authority, but in the central Department, whose inspectors have, of course, a wide range of functions under the bill.

There is no time to examine the Children Bill in great detail, and, as a Government servant, I could not attempt a critical analysis, particularly while it is a measure that is still being debated in Parliament. There remain, however, a few other important provisions to which I should like to refer.

Hitherto Government grant has not been available except for children whose care was required by the decision of a juvenile court. In future, the State will pay 50 percent grant for the services performed by local authorities, and may pay grant to voluntary societies for the improvement of their children's homes. This grant would come from central taxation: the balance would be paid from the taxes which are levied in their areas by the responsible county and county borough courts in the usual way.

In planning for the care of children needing a substitute home the bill specifies private foster-home placement as being, in general, the preferred method. It is recognized that there will be children for whom this type of care is not necessarily suitable, and for such children group homes will continue to be provided.

In developing the type of care that is needed, the emphasis will be on small homes, on family grouping of children of mixed ages and sexes, and on a normal relationship with school and the outside community. Care will be taken to ensure that these children have the same freedom of choice as to types of employment when they leave school that other children have. Although some large homes will continue to exist for some years to come, efforts will be made by staff training and in other ways to reduce the institutional element to a minimum.

The bill further provides for the setting up of reception homes, with facilities for the observation of the physical and mental conditions of children, and of hostels for young people over school age and under 21, where they may live while going out to work or undertaking further education or training. In these hostels, the local authority may also accommodate other young people, which will facilitate the association of the two groups. The bill provides too for the appointment of an Advisory Council on Child Care, which will be made up of persons specially qualified to deal with matters affecting the welfare of children.

The importance of providing for the training of all types of staff employed in the care of children was strongly emphasized in the Curtis committee report. The members regarded this matter as fundamental and issued an interim report, which dealt specifically with the training of staff working in children's homes. As soon therefore as the Home Office became centrally responsible for these services, a Central Training Council in Child Care was appointed, and arrangements were made for the initiation of suitable training courses. Four universities started courses in the autumn of 1947 for students with such previous qualifications and experience as would fit them for a specialized 1-year training course for work as supervisors of training, and a number of local education authorities have undertaken training courses for men and women who will work in children's homes.

The emphasis in syllabus is on the child as an individual, his development, and his needs, and all subjects taught are to be related to that central theme. In planning the courses and in making arrangements for practical training, which has an important part in all the courses, advice and cooperation from the Central Training Council and from the central staff is fully available. Close contact is also maintained with voluntary societies, some of which have done valuable pioneering work in the field of training, and the needs of existing staffs are being met by various types of refresher course. The cost of training to the student in all types of courses is covered by grants for tuition and other expenses, and maintenance where circumstances justify, and this applies to the staff of public and private agencies alike.

I have dwelt on the Children Bill first because it is the measure of greatest current interest, awakening much popular support and exclusively concerned with the welfare of a special group of children. It should be remembered that it is not an isolated measure but follows a series of measures designed for the improvement of social services and applicable to *all* children—not only those who require care outside their own family.

For increased economic security

As well as the comprehensive provisions of the National Health Service Act, shortly to be implemented, and the children's allowances of 5 shillings a head per week after the first child, payable under the Family Allowances Act, 1945, we have the increased economic security of the family which is provided under the National Insurance Act to meet periods of sickness and unemployment, and the National Assistance Bill, whose provisions will assist when additional help is required.

Finally, the Education Act of 1944

Establishment of more nursery schools in Great Britain was encouraged by the Education Act of 1944. This act is one of a series of recent measures for the welfare of British children.

stands out as perhaps the most far-reaching measure of all. This provided for the raising of the compulsory school-leaving age to 16 years—15 being at present the operative age—made primary and secondary education free, encouraged the establishment of more nursery schools and school-meals services, empowered local education authorities to provide clothing where necessary, and placed on them the duty of seeing that adequate recreational facilities for children and young persons exist in their areas. A tremendous advance in provision for handicapped children of all types will result from the act, which not only requires special schools of the more usual type but also envisages boarding homes and schools for some children who are maladjusted, debilitated, or handicapped in other ways.

In spite of this wealth of legislative provision, it cannot be claimed that, even now, the safeguards for the individual child are complete.

The Curtis committee felt it to be right to draw attention to a problem with which they have not been asked to deal, namely, the child neglected in his own home, and many witnesses who appeared before that committee stressed the need for further action in this direction.

We have, as yet, no statutory provision for the prevention of neglect of all types which would provide a constructive service designed to operate in the early stages.

Until this gap is filled, social workers cannot feel satisfied. On standards of training, in preventive work, and in case work generally we have much to learn yet from the experience of other countries.

Nevertheless, when one considers the step forward that has taken place during and since the war, when one realizes the strength of public opinion which is behind any measure designed to improve the lot of children, one cannot but feel encouraged.

Emphasis on family homes

The spotlight is on the Children Bill today and what we do for deprived children. We are creating this children's service largely because of our determination that the special needs of these children should never again be overlooked. Nevertheless, in all that is to be done for their care the emphasis is again and again on supplying the family background that should be the birthright of every child. Social workers everywhere recognize that the most elaborate service one could devise for children could never succeed if this fundamental point were lost sight of.

You will, I hope, forgive me if I have devoted too much time to this new measure. It is new in the sense that it will come newly on the statute book, that it will provide new safeguards and new possibilities for a big group of children needing every help and care; that it gives a new emphasis in the administration of our children's services.

It is not particularly new in the principles of social service to children which it enunciates, and we should be thankful indeed for that fact.

Why is it that the nations seem to get closest to one another when they are considering the welfare of children? Is it so because, broadly speaking, they are conscious of a profound community of purpose? The child does not require artificial settings, special communities, experimental relationships.

I think the only serious danger for child-welfare workers is that in seeking for new methods, we sometimes mistake the method for the goal. In caring for children, can we not best do so by sticking faithfully to the pattern—respect for the individual, helping him to grow in the way that is right for him—not according to some special ideas of our own—protecting and providing the security of family life and of a growing relationship with a normal community?

It is because people working in the field of child welfare know the importance of these things that they can share in the work and experience of different countries with relatively little difficulty, that they can adjust to environmental and cultural differences and still rely on their fundamental principles.

When I saw a lovely home for refugee children in Sweden, with its light, gay rooms, its sense of space and freedom, I did not say to myself, "That is all very suitable for Swedish children." I said, "That is the atmosphere we should try to get in our own children's homes." When I visited a home for Jewish children in France near Paris and realized the soundness of the relationship between those children and the woman who had the care of them, I felt a keen desire to study the methods by which she had been able to give them so great a confidence in her and in themselves, and so the tale would go on if there were time to tell it.

We all know that the child enshrines the future of the race. Those of us who work for children can only be humble before that thought and ask ourselves again and again if our plans, our policies, our methods will help him to grow to a life of personal stability and security, so that he may be able to face all men in peace and love, in confidence and courage. That is the aim of all of us, and we must help one another to realize it.

Reprints available in about 3 weeks

COMMITTEE ADVISES UNICEF ON FEEDING PROGRAMS

WHEN the United Nations International Children's Emergency Fund (UNICEF) was created, it realized that it needed expert technical advice on nutrition in connection with its program of supplementary feeding for children in war-devastated countries.

Accordingly it requested the Food and Agriculture Organization and the Interim Commission of the World Health Organization to appoint a Joint Committee on Child Nutrition to advise the Fund on the best way of carrying out its program.

The committee was specifically asked by the UNICEF to give its attention to the following:

1. The basic principles of nutrition in planning the purchase and distribution of foodstuffs and in the development of feeding programs for pregnant women and nursing mothers, infants, and preschool children, children of school age, and adolescents.

2. The use of dried whole milk, dried skim milk, and cheese in the Fund's operations, and the relative cost of equivalent nutrients in those various forms of milk and milk products.

3. The value, in the Fund's operations, of the provision of vitamin-containing foods, such as cod-liver oil and milk, as compared with that of the provision of vitamins in the form of concentrates or multivitamin and mineral preparations alone.

4. Recommendations about meals for preschool children (as well as meals for children of school age).

5. The relative value of a hot cooked meal in contrast to a cold meal like the "Oslo Breakfast."

In its report to UNICEF, the committee deals with these questions and others that are important in connection with the nutrition of pregnant and nursing women, and of children, and considers how UNICEF can best make use of its resources in assisting governments to improve the nutrition of these groups.

First, it describes the present situation in various countries and shows the great need for activities such as those which UNICEF is undertaking.

Secondly, it outlines the nutritional principles that should underlie practical feeding programs.

Thirdly, it makes a series of specific recommendations about the foods that may be provided by the United Nations International Children's Emergency Fund and by the governments, in order to fulfill, as adequately as possible, the requirements of necessitous groups.

Children in bad condition

When the committee met, in July 1947, the members from Czechoslovakia, Greece, Hungary, Italy, Poland, and China presented a dismal picture of the state of children in these countries. A member of the staff of UNRRA described similar conditions in countries not represented at the meeting (Albania, Austria, and Yugoslavia).

It is clear from these statements, says the report, that in all these countries the children are undernourished and in great need. All these countries were ravaged by the recent war, with its exceptional atrocities, and are now struggling to recover. In all of them mass migration of populations took place. All have been impoverished. Their peoples have suffered and still suffer from lack of adequate food and shelter and bad general hygienic surroundings.

The result is that large numbers of children in these countries are in need of help—of food, clothing, shoes, linen, soap, and medical supplies.

The consequences of underfeeding and diets of poor quality are shown in the retarded growth and development of children, the report continues.

Those in the age group from 7 to 14 years have suffered during important years of their lives, receiving little special attention during the war, as they were beyond the age of infancy. Amenorrhea is common among girls and young women. The morbidity and mortality rates among children are high, much higher than in prewar years. There has been a tragic increase of active tuberculosis: malignant forms are frequent. In many countries, the number of orphans and homeless children is overwhelming. Large numbers of children have been crippled and disabled by war.

Infant death rate high

The report goes on to say that maternal malnutrition and undernutrition have led to a fall in the average weight of newborn babies. The number of premature births and the infant mortality rate are both substantially above prewar levels. Lack of proper food, especially an insufficient supply of clean milk for pregnant and nursing women and infants, is one of the most important causes of this high infant death rate.

The primary nutritional deficiencies result from insufficient calories and protein, the committee says. With the exception of rickets, severe specific vitamin deficiencies are not as common as might be expected. It is likely, however, that the reduced caloric intake is partly responsible for this fact. Sickness appears to precipitate manifestations of vitamin deficiency. Nutritional anemias are common and the incidence of goiter has increased in some countries. Skin diseases are widespread and lack of vitamins has probably contributed to their prevalence.

According to the report, efforts to organize an efficient service to deal with all these problems have been handicapped by lack of money, by the difficulty of coordinating the activities of the many organizations that were cre-

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The Report on Child Nutrition, which is excerpted here, is available in the five official languages of the United Nations. Copies may be had on request from the United Nations International Emergency Fund, 405 East Forty-second Street, New York 17, N. Y.

ated for immediate action after the liberation, by great scarcity of hospitals and other institutions, and especially by lack of trained personnel for child care.

Since the war, UNRRA averted several very real famines and assisted many countries to improve the health and welfare of their children.

With the ending of UNRRA supplies, however, the outlook for the future causes great anxiety; not only may the gains made be lost, but a serious crisis may develop.

It is hoped by the committee that UNICEF may help to prevent that crisis and be the means of perpetuating feeding schemes in these countries.

Besides describing the general condition of the children in the war-stricken nations of Europe and in China, the committee report sets forth in some detail the principles of child nutrition. It discusses the nutritional requirements of children at various ages, and of mothers during pregnancy and the nursing period.

The report notes especially the relation of the nutrition of the mother and that of the baby during the prenatal and nursing periods. In an ill-nourished population, the report says, the stillbirth rate and the infant mortality rate are high, partly owing to an increase in premature births, partly also because infants of undernourished mothers are frequently underweight and may suffer other defects in health.

The committee recommends that supplementary feeding of mothers should be an integral part of the UNICEF program, and says that the advantages of breast milk to the infant are so great as to justify special effort to supplement the diet of the nursing mother as long as she is able to nurse her baby, up to a reasonable age for weaning.

When safe milk for artificial feeding cannot be had, says the report, breast feeding becomes more vital.

Concerning the nutrition of children between infancy and school age, the report notes that growth during the preschool period is slower than in infancy. It is, nevertheless, still rapid, and to sustain it the child needs a diet rich in proteins of high quality, in calcium and iron, and in all the essential vitamins.

As the child acquires teeth, says the report, the choice of foods is greatly widened. The basic foods of the family meal can now be added gradually to the diet, provided they are divided into manageable pieces, and provided also that these foods are given in addition to milk, rather than in place of it.

The preschool child, the report goes on, may not show the ill effects of an inadequate diet in such an immediate and striking way as the infant, so that serious nutritional defects may occur unsuspectedly unless measures are taken to prevent them. Very careful attention, the committee says, should be given to fulfilling the requirements of this age group.

Children should have the first call on foods rich in minerals, vitamins, and animal proteins.

Can use foods available locally

In selecting the foods to meet the essential needs, under emergency conditions, of children of school age, the committee says that full use can be made of all foods available to the population of the area. Children should, however, have first call on foods that are rich in minerals, vitamins, and animal protein.

Concerning the period of adolescence, the report points out that in the time between puberty and the cessation of growth, the nutritional requirements of children reach high levels. For many children this period comes after leaving school, and for this reason their special needs are often neglected.

Since, moreover, adolescents may have been underfed for longer periods than younger children, they may require more nutritional rehabilitation than any other members of the population and may need special attention in feeding programs.

Experience in postwar Europe has shown that adolescent children are frequently very seriously affected by the food shortages, the report states.

At this age, the committee continues, sex differences are sufficiently great to warrant two sets of figures in recommendations for calories and specific nutrients. Although an average figure may be used in making allocations, feeding programs for boys and girls, particularly those in institutions, should be planned in relation to sex.

The committee also describes the needs of children with tuberculosis and those who are seriously undernourished.

Seriously undernourished children, the report says, may have small appetites and be unable to tolerate the mixed

diet of solid foods appropriate for healthy children of the same age.

A mixture of whole and dry skim milk, with the addition of eggs, can be given in semisolid form to such a child until he is able to eat ordinary food.

Medicinal concentrates of vitamins and minerals can be given to meet the child's increased needs and hasten rehabilitation.

Children suffering from tuberculosis need more than the usual quantities of protein, ascorbic acid, and vitamins A and D, says the committee.

These needs can be met by providing governments and UNICEF will work together in the planning and execution of feeding programs.

The committee recommendations concern supplementary feeding in general with particular reference to the part which may be played by UNICEF.

Feeding programs, according to the recommendations, should aim at supplying about one-third of the minimum calorie recommendations (except in the case of infants). Part of the necessary calories will be obtained from foods available in the countries concerned (cereals, potatoes, vegetables, and so

Millions of children in the war-devastated countries are receiving far too little food today.

whole milk, liver, eggs, fruits, and abundant vegetables; ascorbic acid can also be given in synthetic form and vitamins A and D in cod-liver oil or as concentrates.

Present diet defective

In offering its recommendations, the committee points out that pregnant women, nursing mothers, and children of all ages are in need of supplementary feeding in the countries with which UNICEF is likely to be concerned. Their present diet is defective both in quantity and quality.

It is assumed, the report says, that forth), while supplementary foods of high nutritive value should as far as possible be provided by UNICEF.

The aim in supplementary feeding should be to provide as large amounts as possible of animal protein, calcium, and vitamins, these being the nutrients of which mothers and children are in most need.

Attempts should be made to provide one liter of milk daily for all pregnant women and nursing mothers. If it is not possible at first to provide this amount, the committee recommends that UNICEF try to supply a minimum of 600 cubic centimeters daily of reconstituted skim milk, from an early stage of pregnancy or at least during the last 6 months. The provision of a smaller quantity may seriously affect the weight and health of infants.

The use of skim milk may necessitate the addition of vitamin A to the maternal diet unless this already contains adequate amounts of green vegetables and carrots.

It is further recommended that pregnant and nursing women should be given a sufficiency of vitamin D.

Pregnancy and lactation greatly increase the need for the nutrients which the mother must provide for her infant, and care should be taken to see that these are supplied.

Dried whole milk should be provided for babies under 1 year of age who are in need of milk. Babies above this age who are below eight kilograms in weight should also be supplied with dried whole milk.

It may be necessary in some countries to supply sugar and refined cereals for infants.

Infants should be given at least 400–500 international units of vitamin D and 3,000 international units of vitamin A daily, and this may be extended up to the age of 2 years. From 3 to 5 grams of cod-liver oil will supply about these amounts. It is suggested that the Fund should provide these vitamins in this form.

Welfare clinics can help

Supplementary feeding for infants should be planned and carried out in association with welfare clinics.

From the standpoint of nutrition, children between infancy and school age are a most important group, which, though well looked after in some countries, has been neglected in others.

The main supplement provided by UNICEF should be dried *skim* milk the report says; some fat is also desirable. If the amount of spray-dried milk which can be obtained by UNICEF is limited, it is suggested that the preschool group should be supplied with it before older children. The total supplement of milk recommended is 600 cubic centimeters daily; it is recognized, however, that UNICEF may be able to supply only 400 cubic centimeters of reconstituted skim milk. Children between 1 and 2 years of ago who are re-

ceiving skim milk may need to be supplied with sugar.

Preschool children should be given 5 grams of cod-liver oil daily, if sufficient quantities are available after the needs of infants have been met.

The aim should be to provide preschool children with a hot meal (including the milk supplement) during the day, according to the report. This can conveniently be provided in kindergarten schools and day nurseries, where there are such institutions.

Milk most important

The main supplement to the food of children of school age should be milk, of which 400 cubic centimeters daily should, if possible, be supplied by UNICEF as reconstituted skim milk, the committee says. Another 200 cubic centimeters should be provided from local sources, if this is humanly possible.

Additional calories may be supplied in the form of margarine, fortified by vitamins A and D, and by other fats and oils, including lard, some of which might also be fortified. Fortified fats are to be preferred.

Meat or fish would be a most desirable supplement for this age group. The dried milk, and meat, may be given in soup, if a hot meal is being supplied.

It is assumed that the potatoes, cereals, and other foods necessary to bring this meal up to the recommended calorie level will be provided by the governments of the countries receiving help from UNICEF.

For the reasons mentioned earlier in the report, the committee recommends that special attention should be given to adolescents.

Supplementary feeding for this group should be organized wherever practicable: for example, in factories and technical schools.

In addition to the general recommendations, the committee offers some special ones, as follows:

1. The committee is generally in favor of a hot meal of high nutritive value for children of the various age groups, and the provision of such a meal should be the objective in the feeding programs with which UNICEF is associated.

Account, however, must be taken of the facilities for group feeding which exist in the different countries. It is possible to provide a cold meal or snack of equal nutritive value, a familiar example being the "Oslo Breakfast."

2. It is not recommended that UNICEF should spend its money on cocoa and sugar to be used in making skim milk more palatable, because the nutrient content of these foods is low in relation to their cost.

The resources of UNICEF should be utilized in providing the greatest quantities of nutritious food to the greatest possible number of recipients.

It is recognized, however, that in some countries it may be necessary to provide sugar and cocoa to a limited extent for the above purpose, particularly when roller-process dried skim milk is supplied and cannot be included in soup because it is more convenient to provide an uncooked supplementary meal.

3. Supplements of iodine to mothers and children are desirable in countries in which goiter has become more common during recent years, and also supplements of iron where there is widespread microcytic anemia.

Where tuberculosis is rife, special supplements of cod-liver oil may be required for older children.

4. Vitamins A and D can be provided in the form of concentrates, as well as in the form of cod-liver oil. A deciding factor in making purchases should be the cost per international unit.

Ordinary diets will normally supply adequate amounts of vitamin C, but if this is not the case synthetic ascorbic acid or citrus fruits may be provided for children and nursing mothers. In some countries it may be desirable for UNICEF to do this.

Depend on foods for vitamins

5. The committee is of the opinion that the distribution of multivitamin preparations should not be given any prominent position in the policy of UNICEF.

It is recommended that such preparations should be used solely under medical supervision.

6. Proprietary foods are, as a rule, too costly in relation to their food value to justify their purchase by UNICEF as supplementary food.

Expert nutritional advice should always be taken before contemplating the purchase of any food of this kind.

7. Canned horse meat is as valuable a source of nutrients as other kinds of meat and would be acceptable in most of the countries receiving help from UNICEF.

8. The committee wishes to draw the attention of UNICEF to certain foods which might be of value in its operations:

a. Yeast is a valuable supplement in the form of food yeast, brewers' yeast or autolyzed yeast.

b. Soya-bean meal contains protein which can supplement or partly replace milk protein.

c. Canned meat supplied by Canada to UNRRA contained ground fresh bone. Such a food would provide not only protein but also calcium in good amounts and in a form which would be palatable and acceptable to the older age groups.

It is suggested by the committee that UNICEF should explore the possibility of obtaining these foods at a reasonable price for use in some part of its feeding program.

Expert consultation needed

The report further says that UNICEF should continue to consult experts in nutrition and child care throughout the planning and execution of its program, in order to ensure that this is developed along sound nutritional lines.

In an appendix to the report, the committee presents recommendations on calories and specific nutrients, as guides in planning relief feeding. These are given for infants, for children of various age groups, for pregnant women, and for nursing mothers.

The standards for calories and protein recommended are adapted from the "temporary maintenance" levels put forward by the Food and Agriculture Organization at the Meeting on Urgent Food Problems, May 1946 (Technical Supplement No. 1 of Report on World Food Situation, 1946).

At that time "temporary maintenance" was defined as "a level sufficiently high to maintain populations in fairly good health, but not for rapid and complete rehabilitation."

The committee emphasizes that the temporary-maintenance levels are in

(Continued on page 43)

SAFEGUARD WORKING BOYS AND GIRLS

ELIZABETH S. JOHNSON

Director, Child Labor Branch, Wage and Hour and Public Contracts Divisions, U. S. Department of Labor

MANY communities are now starting child-safety campaigns, in harmony with the national campaign begun this month by the Metropolitan Life Insurance Co. with the cooperation of the American Academy of Pediatrics, the National Safety Council, and the Children's Bureau. Though the campaign is placing its main emphasis on accidents to young children in the home, we must not forget the many accidents that kill or cripple boys and girls who are employed. Most of these accidents need not happen if the State and the community are doing everything they can to safeguard their youngsters.

For many communities the most important long-range program for the safety of young workers may be to strive for the passage of legislation that will effectively keep children from entering employment at too early an age and from taking dangerous jobs.

Child workers are more likely to be injured on the job than adult workers, and they are far more likely to suffer injuries that result in handicaps that will last a lifetime.

Boys and girls under 18, employed in manufacturing industries as a whole, have a frequency rate for injuries that is 1½ times as high as that for workers 18 and over. And in some types of manufacturing the rate for the younger group is more than twice as high. These rates are shown by a recent survey made by the United States Department of Labor, which arrived at the rates by computing the number of disabling injuries per million man-hours of employment.

The differences in the injury-frequency rates for the older and the younger workers indicate the need for adequate legal safeguards to keep boys and girls under 18 from employment in occupations known to be hazardous. Even the best State laws have room for improvement in this respect.

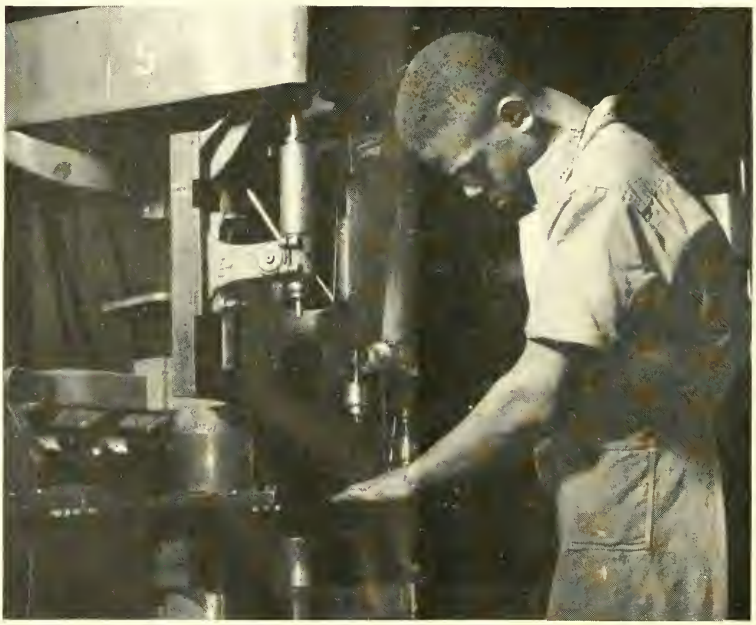
Communities can also bring public opinion to bear on employers who fail to require the use of guards on dangerous machines or tolerate unsafe working conditions, who give inadequate supervision to young or inexperienced workers, or who are careless about obtaining employment or age certificates for all employees under 18 years of age and for those claiming to be 18 or 19 years of age for employment in a hazardous occupation.

The danger of accidents is not the only argument against child labor, but it is an important one, and one that should make any parent—indeed, any public-minded citizen—anxious to protect children against unsafe working conditions.

Part of the work of the Child Labor Branch of the Wage and Hour and Public Contracts Divisions of the United States Department of Labor is to investigate hazards to young workers in industries where there is reason to think such hazards may be excessive.

On the basis of these investigations the Secretary of Labor has authority under the Fair Labor Standards Act of 1938 to issue hazardous-occupations orders, which have the effect of prohibiting the employment of boys and girls under 18 in the occupations that have been found to be particularly hazardous for minors.

Hazardous-occupations orders apply only to establishments covered by the Fair Labor Standards Act: that is, those that produce goods for shipment in interstate or foreign commerce. These orders are enforced through the regional offices of the Wage and Hour and Public Contracts Divisions.



Young workers are more likely to be hurt on the job than adults in comparable occupations.

These orders at present deal with: (1) Explosives manufacturing; (2) Driving or helping on motor vehicles; (3) Coal mining; (4) Logging and sawmilling; (5) Operating power-driven woodworking machines; (6) Occupations involving exposure to radioactive substances; (7) Operating elevators or other hoisting apparatus. (Orders covering additional occupations will be issued from time to time.)

Some States have taken action to prohibit all employment of boys and girls under 18 in one or more of these hazardous occupations, either by the enactment of special laws or through administrative regulation.

Parents who would not for a moment consider letting their teen-age son go to work in a coal mine may thoughtlessly allow him to work outside school hours as "jumper" on a milk truck or news truck.

Many youngsters have been killed or crippled as they jumped off moving trucks or dodged heavy traffic in the street.

Another kind of work that offers unexpected dangers is that of operating elevators, especially freight elevators. Work involving riding on freight elevators, as well as the actual work of operating them, has been found too dangerous for young people under 18.

These jobs may lead to accidents such as the one reported recently in a Chicago newspaper, in which a 15-year-old boy, working as a stock filler during his summer vacation, was trapped between the cab of a freight elevator and the wall of the shaft for 40 minutes, while firemen worked with acetylene torches to free his crushed leg.

What employers can do

Employers, whether or not they are covered by the Fair Labor Standards Act, can help to safeguard child workers by making sure that boys and girls under 18 are not given jobs involving any of the types of work covered by hazardous-occupations orders.

Even farm work is not necessarily safe for children, especially if it involves the operation of farm machinery.

One State industrial commission reports, for example, that a 13-year-old boy was crushed to death last summer when a tractor he was operating overturned.

Among recent cases reported by another State agency is the fatal injury of a 17-year-old boy who was operating a tractor and combine to harvest soybeans. The machine became clogged and the boy stopped to clear it. When he stepped off, his clothing was caught by the revolving shaft, and he was so severely mangled that he died on the same day.

Inspectors in another State in which the shipping of corn has recently become an important seasonal industry found a number of young children operating dangerous machines, or using sharp knives, to cut the ends off the ears of corn; in one corn shed the employer said three workers had lost fingers in a single week.

Use of overcrowded and unsafe busses to carry groups of boys and girls working on farms back and forth has caused the injury of many a youngster.

For every young person killed or maimed at work, hundreds are hurt less seriously.

Child-labor laws, though far from perfect, are intended to protect children from dangerous work, and also from overlong hours, bad working conditions, and employment at too early an age.

When a boy or girl goes to work, the job should be within the protection of existing laws. An illegal job is likely to be either dangerous, substandard, or in some other way unsuitable for children.

State employment services understand this well and have a policy of refusing to refer youngsters to jobs that do not comply with State and Federal child-labor laws.

An immediate step that community organizations and citizens' groups can take toward ensuring the safety of working children is to make sure that employment certificates based on proof of age are required before boys and girls are allowed to start work and that all provisions of the child-labor laws are properly administered.

These organizations and groups can also work with local safety councils and with safety officials in State labor departments to bring about greater safety for working minors.

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Committee Advises UNICEF

(Continued from page 41)

general considerably below the "recommended dietary allowances" of the National Research Council, as revised in 1945, and those recommended by expert committees of the League of Nations in various reports. The "recommended dietary allowances" for calories and protein of the National Research Council are also shown in the appendix, interpolated to correspond to the same age groups for comparison.

Recommendations are also presented with regard to quantities of calcium, iron, and iodine; also of vitamins A and D, thiamin, riboflavin, and ascorbic acid. For fully satisfactory nutrition, however, the committee recognizes that larger amounts of some of these nutrients may be required.

To salvage child life

In its concluding statement, the report says:

This committee, composed of doctors and nutrition experts with experience in the problems of child nutrition and knowledge of the great needs of children and mothers in many parts of the world at the present time, strongly supports the aims of the United Nations International Children's Emergency Fund.

Children in many lands are suffering from the effects of prolonged undernutrition and malnutrition, and from lack of other necessities of life. They need more and better food for satisfactory mental and physical development. Expectant and nursing mothers must be well fed and well cared for, if they are to bear and nourish healthy children.

There can be no more important objective than the salvaging of damaged child life and the building of strong and healthy men and women who can play a full part in the reconstruction of a devastated world.

The world cannot hope for a better future unless it looks after its children.

Much can be achieved by the careful and well-organized expenditure of money and effort on the feeding and care of necessitous mothers and children.

International action to promote the well-being of mothers and children will, moreover, foster a spirit of friendship and cooperation between nations.

WHY A MIDCENTURY WHITE HOUSE CONFERENCE ON CHILDREN?

At the latest count, 32 States have commissions or committees on children and youth. Many of these are putting their plans for a 1950 White House Conference at the top of their agenda. As interest in this significant event spreads in States and communities, the values to be gained from such a conference grow sharper in outline. The statement that follows epitomizes the many arguments that have been given for mobilizing the interest and energies of citizens in working toward this event.

Many reasons point up the need for holding a conference in 1950 to give the Nation a chance to take a look at what children need for wholesome growth and development, how many of them are getting the opportunities they need, and what the Nation's goals for children should be for the decade ahead.

The year 1950, the halfway mark of the century, after two world wars and a major depression, is a logical time to take stock of children and the Nation's efforts and resources for serving them.

The world in which today's children are growing up is in an upheaval of change—social, political, economic, and scientific. New forces, such as the radio, motion pictures, comics, and new inventions, are affecting their environment. These new forces and the changes taking place need to be examined for their effects upon children.

The past 50 years have seen more developments affecting the health, education, and welfare of children in this country than any other 50 years in history. But the benefits from the advances are inequitably distributed. Far more is known than is applied. In this critical time it is vital to measure the gains and the gaps so as to improve the score for all children.

Many millions of children the world over have been the victims of war—destroyed, orphaned, maimed, starved, tortured, undernourished. American children, though suffering much less than those in other lands, have not entirely escaped. They have experienced family tensions and anxiety, separations, shifting homes.

They have felt the repercussions of violence and cruelty of history's most disastrous war and been subject to the after-effects of general upheaval. These effects need to be evaluated.

New directions are needed. Progress in human relations lags far behind progress in the physical sciences. New ways of assuring to people greater happiness, security, and peace must be discovered. Focusing on the physical, emotional, mental, and social growth of children, on their relationships in families, communities, the Nation, and the world can help lay the foundation for better understanding of all human relationships.

In a great tradition

A Midcentury White House Conference on Children would be the fifth such conference under Presidential auspices. Each decade since 1909, under both Republican and Democratic administrations, there has been a conference to consider the welfare of children. Each of these conferences differed in some respects from the others.

The first, held in 1909, was called by President Theodore Roosevelt. Its primary concern was the dependent child. It set forth principles in this field that have guided social workers in all the years since. It took a long step toward creation of the Children's Bureau in the Federal Government to speak for the interests of all children.

The second was held in 1919, initiated by President Wilson. It emphasized minimum standards of child welfare and focused national attention upon child-labor legislation, protection of mothers and infants, educational opportunity, and children in need of special care. The Washington conference was followed by eight regional conferences. The Nation-wide concern for maternal and infant care aroused by these conferences helped pave the way for the Sheppard-Towner Act, under which the Federal Government for a limited period provided funds to aid the States in care of mothers and infants.

The third was held in 1930, called by President Hoover. It brought together representatives of all fields concerned with the welfare of children—medical, public health, education, and social services. The findings represented the most comprehensive diagnosis of the needs of *all children* and statement of goals for their welfare and protection that ever had been made. This conference contributed to the organization of the American Academy of Pediatrics. The many reports that resulted from the conference have been a major resource for all groups working in the fields of child care.

The fourth was held in 1940, called by President Franklin D. Roosevelt. Meeting as war approached, the conference had as its main consideration the welfare of children in a democracy. It defined objectives which would build toward democratic citizenship for children and uphold the strengths of democracy in their environment. It emphasized the need to mobilize resources—Federal, State, and local—to strengthen services to children.

Katherine Glover

• IN THE NEWS

For the Health of the World's Children

Katharine F. Lenroot, Chief of the Children's Bureau, who is the United States representative on the Executive Board of the United Nations Children's Emergency Fund, attended the first part of the meeting of the board. The meeting took place at Geneva, Switzerland, July 16–22, 1948.

As one of the three United States delegates to the First World Health Assembly, held at Geneva, Switzerland, June 24–July 24, Dr. Martha M. Eliot, Associate Chief of the Children's Bureau, took part in the deliberations of

the Assembly. Dr. Thomas Parran, Medical Director, Public Health Service, Federal Security Agency, was chairman of the delegation. The third delegate was Dr. James R. Miller, Trustee, American Medical Association.

Dallas Improves Care for Premature Infants

In Dallas, Tex., prematurely born babies now have a better chance for life, as a result of the active interest and cooperation of many individuals and agencies.

Parkland Hospital, the city-county hospital of Dallas, has recently completed a 22-bed unit for premature babies, and it was filled to capacity within a week.

When the unit was projected, the State health department offered assistance and loan equipment, but only if the hospital provided more adequate facilities. The hospital was unable to finance in full the construction of the unit, but local labor unions, contractors, architects, and others, stepped in to help, and donated not only the labor for the remodeling, but also some of the material, such as flooring, electrical appliances, and paint. The State health department advised on standards for constructing the unit, and lent basic equipment for the new center, including incubators, bedside tables, and scales.

Through the Dallas Pediatric Society a pediatrician was appointed to help with the project.

The city health department is providing follow-up nursing services for all premature infants discharged from the hospital.

North Carolina Fights Polio

Facing one of the worst epidemics in its history, the State of North Carolina has rapidly organized its resources to save lives of children and to prevent crippling. Medical and hospital care are being provided in several centers in different parts of the State so that children can receive care near their own homes. This development of several hospital centers is in contrast to conditions during the 1944 epidemic, when care was concentrated in one center.

A notable advance is the establishment of physical-therapy services as a part of the total care provided in the hospital centers.

Convalescent care is being provided at several centers. As rapidly as possible children will be transferred from hospital beds for acute cases of poliomyelitis to convalescent facilities.

For Research in Child Life

Organization of a clearinghouse of current research in child life has begun with the appointment of Dr. Clara E. Councell to the staff of the Children's Bureau. Dr. Councell will be responsible for setting up and directing the clearinghouse as an aid to professional people in the exchange of information on research.

The clearinghouse is being developed in response to recommendations of professional organizations and advisory committees to the Bureau, primarily to aid research workers and organizations in keeping abreast with research in progress.

Research in the social, cultural, psychological, and physical aspects of child growth and development, in cultural patterns affecting family life, and in the development of health and welfare services for children is now going on in many universities, schools, and centers throughout the country, but until now there has been no one place where a research worker in the field of children can find out what other people are doing in the same field or in fields related to this work.

Many projects require months, and even years, for completing. Thus it is some time before the published findings become generally available. Meantime, work on one project might be modified and made more effective if researchers knew about others going on at the same time in related fields. The Children's Bureau clearinghouse, it is hoped, will provide a systematic way of keeping professional research workers informed on current projects as they are planned and as they develop. It should also tend to stimulate more research in child life, particularly some specialized fields where it is lagging or lacking altogether.

Dr. Councell comes to the Bureau from the Institute of Inter-American Affairs, an agency of the Department of State, where she assisted in keeping professional people in Latin America informed of current research in medicine and public health being carried on in the United States. Previous to this post she was on the staff of the United States Public Health Service, working primarily in the field of public-health methods.

For Children With Rheumatic Fever

A program of comprehensive services to children with rheumatic fever is to be developed during 1949 by the New York State Department of Health with the assistance of a grant of $50,000 from the Children's Bureau under the Social Security Act. This makes 25 States with programs for the care of children with rheumatic fever.

The New York program will give care to children in Syracuse and Rochester health districts. These two areas will serve as models for the development of other rheumatic-fever programs. Complete coverage of the State is the goal.

The Syracuse district comprises four counties, with a population of about 466,000; the Rochester district, three counties, with a population totaling about 530,000. The two districts have been chosen because of the availability of qualified consultant services and of special institutions for convalescent care, the presence of medical schools in the two cities, local interest in rheumatic fever, and the probability of developing strong community support.

A broad range of professional services has been planned. Diagnostic and consultation clinics will be held both in the two cities and in outlying areas for children having, or suspected of having, rheumatic fever.

Medical and hospital care in pediatric units of general hospitals will be provided for acutely ill children, either with first or later attacks of rheumatic fever. Existing convalescent facilities in the two cities will be utilized. The program also contemplates developing foster-home care for convalescing children. Active case-finding and follow-up programs have been outlined.

Georgia Commission Studies Laws Concerning Children

The Governor of Georgia has recently reactivated the children's code commission to study the laws affecting the lives of children. A group of 10 persons, representing leading State agencies and organizations, the legislature, and the courts, has been appointed to serve on the commission. Miss Florence van Sickler, of the State council of social agencies, Atlanta, is acting chairman.

Prenatal Clinics Can Point to Good Record

Of the 84,870 women in Alabama whose infants were born in 1947, 10,015 attended the health-department prenatal clinics during their pregnancy. The maternal mortality rate for women who attended the clinics was 1.2 per 1,000 deliveries, or one-half the rate (2.4 per 1,000) for those who did not attend. The stillbirth rate was 20.4 per thousand deliveries for the infants of women who attended the clinics, as compared with 29.0 per 1,000 deliveries among those who did not go to a prenatal clinic.

Nutritionists Hold Workshop in Supervision

A 3-week workshop for nutritionists in supervisory positions in State health departments was held July 1–20 by the Department of Public Health Nutrition of the University of North Carolina School of Public Health. Nutrition supervisors from 14 State health departments attended, as well as one coordinator of field experience for graduate students in public-health nutrition.

Major areas of discussion included the nutrition supervisor in the organization of the health agency, the nutrition supervisor and program planning, and the job of supervising.

Consultants assisting in the workshop represented many fields. These include public administration, personnel management, public-health nutrition, hospital administration, nutrition research, health education, public-health nursing, agricultural extension, social sciences, public welfare, and education.

• FOR YOUR BOOKSHELF

TRENDS IN SOCIAL WORK, as reflected in the Proceedings of the National Conference of Social Work, 1874–1946, by Frank J. Bruno. Columbia University Press, New York, 1948. 387 pp.

In its three-quarters of a century the National Conference of Social Work, the successor of the original Conference of State Boards or Conference of Charities (later the National Conference of Charities and Correction), has either led the country's thinking on social problems or, as Mr. Bruno says in his "Trends in Social Work," has reflected the current thinking of the times.

Here we can observe the changes that have taken place in attitudes toward such things as poverty, child dependency, mental illness, and the control and treatment of delinquency and crime.

Mr. Bruno presents these developing ideas in three periods, each a quarter of a century. The subjects are those that "seemed to be prominent in the minds of conference members," many of whom have been outstanding leaders. Some of them are merely names to present-day social workers, who little realize what high intellectual capacity they had and how deep was their passion for social justice. It is good to have these attributes brought to our attention and to be reminded of our heritage from these earlier social planners.

It is not only in the last quarter century that social-work leaders have concerned themselves with the causes of social problems and their prevention. This is part of our inheritance, though Mr. Bruno believes that the National Conference of today still reflects a lack of concern for the underlying causes of poverty, which was one of the weaknesses of its earlier approach.

In reporting trends Mr. Bruno has not confined himself only to records of the National Conference of Social Work, but has discussed also other movements and organizations that represent milestones in social progress. One of these is the establishment and service of the Children's Bureau. He has much that is favorable to say of the Bureau's leadership, but he confines his comments to the leadership offered under the Bureau's basic act, and says nothing of its influence in the development during the last 12 years of public social services to children under the Social Security Act.

On the whole, Mr. Bruno's book gives a stimulating picture of social-work planning on an ascending scale.

Mary S. Labaree

A COMMUNITY PLANS FOR ITS CHILDREN; final report, Newport News (Va.) project. Federal Security Agency, Social Security Administration, U. S. Children's Bureau Publication 321. Washington, 1947. 54 pp. Single copies free.

The Newport News project was a wartime experiment, planned in 1942, to discover methods by which community resources could be quickly and effectively mobilized to meet the problem of prevention and control of juvenile delinquency. The Bureau of Public Assistance of the Social Security Board and the Children's Bureau of the U. S. Department of Labor, in cooperation with the Virginia Department of Public Welfare, sponsored the project.

Two progress reports have been issued jointly by the sponsoring Federal agencies at two stages in the development of the project. The third and final report summarizes and evaluates the project from its initiation, through its interruption in July 1944, to its termination on March 1, 1945.

ANNUAL REPORT, 1947. Play Schools Association, 119 West Fifty-seventh Street, New York 19, N. Y. 20 pp.

That the Play Schools Association had requests during 1947 for 7,000 of its publications—twice as many as in 1946—from all 48 States and from many foreign countries, is testimony to the interest people are taking in the work of this organization.

The association, describing its work, says in this annual report that it attempts to bring together children's disjointed experiences and to integrate them in a program for coordinated living. Play schools, it says, "develop work-play activities that contribute to emotional growth; they demonstrate the use of carefully chosen play materials and equipment that foster and promote that growth; they are constantly sensitive to the need for providing experiences, skills, and interests which are not occasional or haphazard or mere busy work, but which are designed to enrich children's lives" in the future as well as in the present.

Marion L. Faegre

PSYCHIATRY FOR THE PEDIATRICIAN, by Hale F. Shirley, M. D. Commonwealth Fund, New York, 1948. 442 pp. $4.50.

Despite the quantity of current psychiatric literature, there has been a notable lack of translation of knowledge of emotional processes and personality problems as they apply to other medical fields. The need for such an interpretation has been very great in pediatrics, and this book makes an excellent start in conveying psychiatric ideas into the practice of pediatrics.

Written for the psychiatric novice, this book expands current ideas of growth and development and stresses the emotional phases of this maturation process. The problems involved in aberrations of normal growth are discussed under physical, intellectual, emotional, sexual, and finally environmental factors. Case histories are used liberally and well. Considerable space it allotted to methods of elucidation of children's problems and the practices of therapy that are current today.

Henry H. Work, M. D.

A GUIDE TO CHILD-LABOR PROVISIONS OF THE FAIR LABOR STANDARDS ACT. Wage and Hour and Public Contracts Divisions, United States Department of Labor. Child-Labor Bulletin No. 101. 16 pp. Free on request from the Wage and Hour and Public Contracts Divisions of the United States Department of Labor, Washington 25, D. C.

In addition to listing the child-labor provisions of the Fair Labor Standards Act, which set a general minimum age of 16 for employment subject to the act, the bulletin lists the seven hazardous-occupations orders, which establish a minimum age of 18 in occupations declared by the Secretary of Labor to be hazardous for young workers. Easy-to-read questions and answers are included to help employers in their efforts to avoid violations.

As a further aid the bulletin calls attention to other Federal laws having child-labor provisions and indicates to employers how they may obtain proof of age for all the minors they employ.

REPORT OF THE NATIONAL CONFERENCE ON SOCIAL WELFARE NEEDS AND THE WORKSHOP OF CITIZEN'S GROUPS. National Social Welfare Assembly, Inc., 1790 Broadway, New York 19, N. Y. 1948. 69 pp. Single copies, 25 cents; 10 or more, 15 cents.

"This report is prepared for the individual citizen and the national or local organizations that desire to help meet the needs of people." These words, on the flyleaf, give an apt description of this report.

The National Conference on Social Welfare Needs, which met January 26–28, 1948, was sponsored by the National Social Welfare Assembly to inventory the social needs of the Nation and to develop action proposals to meet these needs.

The work of the conference was done by commissions on education, health, housing, recreation, social security and welfare, special services for children and youth, and citizen participation and the reports of all these groups, as adopted by the conference, are included in the pamphlet.

National citizen's groups had been invited to participate in the conference and in a Workshop of Citizen's Groups. The workshop considered and proposed ways for individual citizens and citizen's groups to participate in meeting social-welfare needs locally.

Over 350 persons attended the sessions of the six commissions, the conference, and the workshop.

Edith Rockwood

FACTS AND FIGURES ABOUT INFANTILE PARALYSIS. National Foundation for Infantile Paralysis, 120 Broadway, New York 5, N. Y. Pub. 59. Revised December 1947. 30 pp.

This useful bulletin gives the incidence of poliomyelitis in the United States as a whole and in the individual States from 1915 through 1946 and the mortality from 1915 through 1945. Information from a few areas is analyzed further to bring out such factors as age, sex, and prognosis. In addition, information regarding the incidence of poliomyelitis in Canada and Europe is included for the first time.

Betty Huse, M. D.

FOOD FOR YOUNG CHILDREN IN GROUP CARE, by Miriam E. Lowenberg. Federal Security Agency, Social Security Administration, U. S. Children's Bureau Publication 285. Washington. Revised 1947. 40 pp. Single copies free.

This bulletin was first published in 1942 to aid persons responsible for the feeding of young children in groups, as in day nurseries, nursery schools, and day-care centers for children of working mothers. Because of many requests the bulletin has been reissued, with revision in keeping with recent thought and information.

THE REHABILITATION OF THE PATIENT; social case work in medicine, by Caroline H. Elledge. J. B. Lippincott Co., Philadelphia, 1948. 112 pp.

Out of her extensive experience in work with handicapped persons, Mrs. Elledge has condensed into a small book a review of the social-work implications of the rehabilitation of handicapped persons. The volume should be of value not only in the training of medical social workers but also in the orientation of other professional persons working with handicapped persons. Physicians, nurses, rehabilitation workers, teachers of exceptional children, and social case workers in family or child-welfare agencies should profit from reading this book.

In addition to its brevity the book has the advantage of making interesting reading. It is freely interspersed with well-selected case histories. Necessarily the case histories are simplified and may at times seem dramatically successful. Except by inference, they do not attempt to instruct the reader in the technique of case work with handicapped clients, since the basic skills of the medical social worker are deemed to be just as readily applicable to the problems of the handicapped person as to those of other patients. Rather an attempt is made to present the usual types of problems encountered so that the medical social workers will be on the look-out for such problems and will participate more effectively in the teamwork approach to their solution.

Two chapters entitled, "Whose job is rehabilitation?" and "Teamwork in rehabilitation" present the role of the medical social worker and her relation to other workers and community resources in the rehabilitation of handicapped persons.

Three other chapters, entitled "How does he feel about his handicap?" "What are his future possibilities?" and "Some special considerations in success and failure" recount in simple though comprehensive fashion the attitudes of patients, family, and professional workers which must be considered in aiding the patient toward social adjustment.

For hospital internes, ward nurses, and other workers who do not ordinarily consider themselves to be in the field of rehabilitation but are more often concerned with the care of patients with acute illness, the book can be recommended because of the philosophy embodied in Mrs. Elledge's statement that "the rehabilitation process starts the moment it is known that a physical impairment is to be reckoned with in the future."

Samuel M. Wishik, M. D.

A limited number of copies of the following reprints from *The Child*, in the field of mental health, are available for distribution. Single copies may be had without charge until the supply is exhausted.

Coordinating Mental-Hygiene Work for Children. Briefed from "Mental Hygiene for Children and Youth," a joint committee statement submitted in February 1945 to the committee on plans for children and youth of the National Commission on Children in Wartime. (The complete statement, in mimeographed form, is also available.)

Mental Hygiene in the Child-Health Conference. By Martha W. MacDonald, M. D.

Mental-Health Services in the Health-Department Program. By Kent A. Zimmerman, M. D.

CALENDAR

Sept. 26–Oct. 1—Thirtieth National Recreation Congress. Omaha, Nebr.

Sept. 27–29—President's National Conference on Industrial Safety. Sponsored by the U. S. Department of Labor. Washington, D. C.

Sept. 27–29—United States National Commission for UNESCO. Fifth meeting. Boston, Mass.

Oct. 7–9—National Association for Nursery Education. Chicago, Ill.

Oct. 10–13—National Council of Negro Women. Washington, D. C.

Oct. 10–17—Second Brazilian Conference on Child Care and Pediatrics. Curitiba, Paraná, Brazil.

Oct. 16–17—Executive Section, National Child Welfare Commission, American Legion. Miami, Fla.

Oct. 18–21—National League to Promote School Attendance. Annual convention. Birmingham, Ala.

Oct. 18–22—Thirty-sixth National Safety Congress and Exposition. Chicago, Ill.

Oct. 19–22—American Dietetic Association. Thirty-first annual meeting. Boston, Mass. (House of delegates meets Oct. 18.)

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Page 42, Library of Congress photograph.

FOR EVERY CHILD

In this issue of *The Child* Geraldine M. Aves, of England's Ministry of Health, tells of the potentialities of social services in that country's planning for the welfare of its children.

In her definition of social services to children, Miss Aves places emphasis on giving *every child* maximum opportunity. This idea represents one of the great advances we have made in the social service field.

We are getting away from the idea that social services are identified with classes of people. We are beginning to realize, first, that disaster may strike anywhere and that social services therefore must deal with human problems wherever they are; secondly, that social services are a resource that provides opportunity for everyone to develop his personality "for his own happiness and for the benefit of society."

Miss Aves makes us keenly aware of the fact that what our country does, or fails to do, for its children affects the welfare of all children everywhere. This places a serious responsibility upon all of us engaged in child-welfare work. It means that the vision and foresight that we bring to our work, the soundness of our philosophy, and the success of our efforts will be weighed and measured by other countries in their efforts to find ways of improving child life in the world.

It is often true, however sadly, that social advances occur on the heels of a major disaster. In England the Second World War brought the realization that the central Government must take more responsibility for providing social services to the people, and employment of trained and experienced social workers was recognized as a necessity.

In this country the financial depression of 1929 brought greater realization of public responsibility for people in need and of the growing concept of public social services, with the Federal Government sharing in these responsibilities. Here, as in England, the war years brought into sharp focus the effects upon family and child life of dislocations, separations, movements of population, crowded housing, and lack of community facilities.

Thirteen years ago the Social Security Act was passed—a great step forward in providing economic aid for certain groups, and in public acceptance of responsibility, even though limited, for the social well-being of the people. This act needs to be expanded and broadened so that public responsibility for meeting the problems of families and children may be more fully met.

England's "Children Bill," which became an Act of Parliament June 30, 1948, has great significance for child life. It embodies certain fundamental concepts that are significant in the development of child-welfare services here. It places responsibility first upon the local authorities. Thus, it keeps services to children close to the families and the communities. And it provides that the central Government must share in the cost and must carry certain overall responsibilities, so that children may be equitably served. This act, along with other proposed measures, is designed to meet the needs of *all* children.

It carries *full* responsibility for children deprived of normal home life. Parental rights will be safeguarded in that children can be cared for while remaining under the guardianship of their own parents. It recognizes the need for a variety of services for children who are dependent, neglected, or delinquent, such as foster-family homes, institutions, temporary detention homes, and reception homes. It emphasizes qualified personnel.

We in the United States also have recognized these needs in planning for child welfare in this country. It remains to be seen how quickly and how adequately they will be fulfilled for the benefit of all our children and for society as a whole.

Mildred Arnold

Director, Social Service Division,
Children's Bureau.

VOL. 13, No. 3 SEPTEMBER 1948

the CHILD

published monthly by the
Division of Reports
CHILDREN'S BUREAU
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SOCIAL SECURITY ADMINISTRATION
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CHILDREN'S BUREAU
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Publication of THE CHILD, monthly bulletin, was authorized by the Bureau of the Budget, May 12, 1926, to meet the needs of agencies working with or for children. The Children's Bureau does not necessarily assume responsibility for the statements or opinions of contributors not connected with the Bureau. THE CHILD is sent free, on request, to public officials and libraries. For others, the subscription price is $1 a year. Single copies, 10 cents. Send remittance to the Superintendent of Documents, Government Printing Office, Washington 25, D. C.

U. S. GOVERNMENT PRINTING OFFICE: 1948

OCTOBER · 1948

the CHILD

INTERNATIONAL CONGRESS ON MENTAL HEALTH MEETS IN LONDON

LAWRENCE K. FRANK, *Director, Caroline Zachry Institute of Human Development, New York City*

Mr. Frank served as executive secretary of the Central Commission on Mental Health and World Citizenship for the International Conference on Mental Health. He was chairman of the International Preparatory Commission for the Conference and is now chairman of the interprofessional committee of advisers to the World Federation for Mental Health.

ONE promising sign of the times is that it is scarcely necessary today to explain that the phrase "mental health" no longer suggests only the care of the "insane." It is true that the need for improved care of the mentally diseased and for the expansion of clinics to diagnose and treat men, women, and especially children, is urgent. But today we are concerned more and more with the possibilities of guarding and advancing the mental health of everyone, especially of babies and children and adolescents, as a program of human conservation.

This positive approach to mental health as an effort, not only toward prevention, but more especially for happier, saner, more humanly desirable living was emphasized and reemphasized at the International Congress on Mental Health, held in London, August 11 to 21. Indeed this third international congress will long be notable for the enlarged conception of mental health which was there presented and discussed and for the new kind of program and meeting at an international, professional meeting.

Readers of *The Child* will be especially interested in what was said and done at the congress as respects children and youth. But to understand how significant this was, they should first recognize the underlying aim of the whole congress plan and some of the difficulties, professional, international, and personal, which were faced at London and in the preliminary organization and arrangements which began at least 2 years ago.

At the outset, it was decided to organize the congress on new lines. Instead of having an overcrowded program of many individual papers, it was planned that before the congress began, groups would be asked to meet, to study, discuss, and write up their findings on various aspects of mental health and also to formulate conceptions and theoretical approaches. Thus it was hoped that the congress would receive, not the findings or theories of single individuals, but the product of group thinking and critical discussion.

It was also decided to attempt an even more ambitious and difficult task, namely, to ask that preparatory groups be made up, not only of psychiatrists and psychologists, but of representatives of all the relevant professions and disciplines—medicine in general, social work, nursing, sociology, anthropology, education, ministry, political science, law, economics, and so on.

This larger, more embracing view of mental health and this multidisciplinary approach to its problem reflect the growing realization that mental health is a social-cultural problem for which we need the resources of all the relevant knowledge, skills, experience, and understanding of these different professions. It also expresses the conviction that, for mental health, we need to go beyond the clinical diagnosis and treatment of individuals to the study and reorientation of our whole social life and cultural traditions.

Thus the plan for the International Congress was shaped by a conviction of the urgent necessity for combining and pooling all the knowledge and understanding of the social sciences and the psychiatric and educational professions, since no one profession could effectually grasp or formulate this larger problem nor single-handedly undertake to deal with it.

For over a year, therefore, 300 preparatory commissions worked, all over the world. Some 5,000 individuals in 27 countries participated actively in these discussion groups and formulated their findings, with recommendations and questions. The reports of these preparatory commissions were then sent to London, where small editorial groups summarized and digested these, noting conflicts and agreements in recommendations. These original reports and summaries were then studied and discussed by an international preparatory commission, composed of men and women from 10 countries, drawn from the professions of anthropology, philosophy and theology, political science, psychology, psychiatry, and sociology.

This international preparatory commission undertook two tasks: (1) To present to the Congress at each plenary session a summary of the preparatory commissions' reports on the topics for each day's session, together with a considered statement of the international commission's own views on these questions. The presentation was made by a member of the commission chosen for the purpose. (2) To formulate a statement on the major theme of the congress, Mental Health and World Citizenship, which would focus present-day knowledge and understanding and would also briefly indicate what the newer approach to mental health means in terms relevant to the urgent problems in each country and internationally.

This statement by the international preparatory commission was examined and discussed during the congress by 20 study groups, composed of persons who had participated in preparatory commissions during the previous year and who therefore brought the thinking of their group to the discussion of the statement. The results of these group discussions were then presented to the congress on the last day as supplement-

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The International Congress on Mental Health combined three separate, but related conferences: Aug. 11–14, the International Conference on Child Psychiatry; Aug. 11–14, the International Conference on Medical Psychotherapy; Aug. 16–21, the International Conference on Mental Hygiene. This report deals with the last of these three.

ing statements, amending, criticizing, and, in some cases, opposing, the statements made by the international preparatory commission.

It will be clear from this very condensed description of the plan and procedure that the congress attempted to develop a truly cooperative approach, utilizing the specialized knowledge and experience of the different professions and disciplines, and the differences arising from ethnic and cultural traditions and the unique experiences of different countries.

Moreover, the congress by this procedure sought, and to a surprising degree attained, a consensus on the aims and purpose of the mental-health movement which is of immense significance for the future. When one recalls the number and variety of different schools of thought and of conflicting theoretical positions in psychiatry and psychology, among professional groups concerned with mental hygiene, and the longstanding aloofness and—let us be candid—sometimes outspoken contempt expressed by many social scientists for psychiatry and by psychiatrists for social science, this congress is indeed memorable as the beginning, we may hope, of a new period of interprofessional understanding and cooperation.

What is of major importance and should be reemphasized here is that the congress, with only a few dissenting opinions and qualifications, took a stand on some questions of the largest significance for all those concerned with children and youth, not only professionals like teachers, social workers, nurses, physicians, group workers, and so forth, but parents as well.

Here is where the readers of *The Child* should take note, especially since the congress has reaffirmed what many of them have long believed, or have wished to believe against strongly worded contradictory teaching and has asserted what some in the field of child care, welfare, education, and therapy have long denied.

In the first place the congress accepted and, judging by the discussions, approved, the conviction that mental health is a positive goal, and, in the words of the constitution of the World Health Organization of the United Nations, agreed that mental health, like physical health, is not merely the absence of disease or infirmity. This assertion, like the conviction underlying public health and public welfare, marks a significant advance toward the conception of human conservation as not only humanly desirable, but as socially achievable. To many of those who are working in these fields this may seem almost a truism, but if they will reflect a bit they will realize that the idea of guarding, protecting, and actively fostering human welfare, as an attainable social ideal, is for many people a novel and even disturbing idea. It conflicts with so many of our traditional beliefs that poverty, disease, premature death, ignorance, the many forms of human defeat and unhappiness, are not only inevitable, but are necessary and even desirable for various reasons.

It is indeed an indication of a far-reaching step to have this positive assertion reiterated to offset these defeatist beliefs of the past. It should strengthen the efforts and revive the faith of all those who, in different capacities and under different auspices, are laboring for the common good of mankind, faced on all sides with the evidence of disorder and conflicts and the human misery of the war.

The congress has also asserted that we can and we must do something constructive because today we are gaining the knowledge and developing the skills, which if we will but combine and learn to use constructively, will show us the way to develop a humanly desirable way of life, socially and individually.

The congress also asserted and, with all possible emphasis, affirmed the conviction that the crucial problem for social welfare, for human development and mental health, is the improvement of the care, rearing, education, and training of the child from birth on. Here again the congress concurred in the words of the World Health Organization that "the healthy [in this larger

Human nature, essentially flexible, is patterned by parents, teachers, and others, who help to mold the child into a member of his society.

807268—48

sense] development of the child is of basic importance; the ability to live harmoniously in a changing environment is essential to such development."

Here again this may seem almost a platitude to many, professionals and lay, but the congress went on to give these convictions an expression, in recommendations, which is at once highly general (so as to be applicable to different countries in different stages of development), and also highly specific as to the full implications of this emphasis upon child development.

In the statement prepared by the international preparatory commission and discussed by the various study groups, the position was taken that the process of human development offers many possibilities for advancing mental health, not only in infancy, childhood, and adolescence, but at each stage in the life career when the human personality is faced with new possibilities and changing interpersonal relations.

As briefly stated, everyone who has any contacts with the child is important for mental health, which is therefore to be seen, not as the sole responsibility of psychiatrists, psychologists, social workers and nurses, teachers, and other professionals, but as the great opportunity and initial responsibility of parents. It is the parents who can, and do, largely shape and pattern the remarkable plasticity of the human being.

Human nature flexible

The congress, with some strong objection and suggested modifications from a few, but with apparently an overwhelmingly favorable response, accepted the assertion that human nature is much more flexible and plastic than hitherto has been realized. Through this essential flexibility of human nature the child's self is everywhere shaped and patterned by parents and other guardians and teachers of the young, who thereby mold the child into a member of his society. Each individual is therefore a product of his culture and as such develops his idiomatic personality in and through the interpersonal relations with parents, brothers and sisters, grandparents and other relatives, teachers, and others.

It is noteworthy therefore that the congress departed from both the pessimistic views of human nature, often expressed by some of the psychiatric group and by some theologians, and by some geneticists. The congress likewise rejected any unrealistic beliefs in man's innate virtue. The congress' view is that scientific study today has shown that human nature is plastic and is molded by each social-cultural group and by each family. These convictions do not deny the importance of biological processes nor ignore the genetic basis of many individual differences. They assert that for social and mental health there are immense possibilities in human nature upon which we can rely for advancing mental health and improved human relations, possibilities at each stage of maturation which we have scarcely recognized.

Group institutions can be modified

The congress likewise accepted with seeming approval the statement that social life is also plastic and capable of being reorientated and redirected. Here again this view contrasts sharply with the long-cherished conviction that the political, economic, social, and legal institutions of a group are fixed and unchangeable, a part of nature beyond man's reach or modificability.

While stressing the great resistance to change in social institutions and the refractoriness, at later ages, of human nature, to modification, the congress' view is that there are promising avenues of constructive endeavor opening with the advance of knowledge and the development of new insights, so that we can actively move forward toward progressive achievement of mental health.

In this view, mental health is not a fixed static condition, but an active way of life, a way of living within the context of interpersonal relationships so that the human being can be at peace with society because he is at peace with himself.

Now in much of this the readers of *The Child* will probably be in agreement and may ask whether this is all that was accomplished, important as it is to reiterate these more hopeful and constructive convictions about human nature and society.

The congress did go on and make what is perhaps the most important contribution of all in this whole field. Here is where all those concerned with child welfare should be most directly interested, because it bears directly upon all the organizations and programs for children, all the professions and agencies. The congress has indicated that those who have been engaged in the diagnosis and treatment of individuals should increasingly recognize that in their patients or their clients are expressed the conflicts, the incongruities, the inadequacies, the discrepancies, and other symptoms of our "sick society" and disorganized culture. Moreover, the clinician or case worker should ally himself or herself directly and actively with those in the social sciences and applied social sciences, in order that these insights and dynamic conceptions of personality development and expressions may be utilized in all social planning and social administration, in drafting social legislation, in carrying out programs of all kinds which touch the lives and feelings of people.

Likewise it is important that economists, political scientists, sociologists, lawyers, and others in the social-science field, including anthropologists, should recognize and learn to utilize these new insights, these dynamic conceptions of human nature so that their thinking, their research, and their various proposals will be guided by modern ideas, not by the eighteenth and early-nineteenth century ideas of John Locke, Adam Smith, and Jeremy Bentham.

In other words it is imperative that clinical workers recognize more clearly that their patients or clients are products of the social life and traditional culture and that the social scientists who study statistical data of large-scale regularities should recognize that these are the expressions of many individuals, often with warped, twisted, disordered personalities who, at whatever cost to social life and to themselves, are releasing their anxieties, their guilt, their hostility in our political, economic, social, and family life.

This points to a synthesis of the psychiatric with the social sciences which calls for an enlarged awareness and new way of thinking by both clinical and statistical groups. The fruitfulness of this has already been shown by the few individuals who have begun to do this multidimensional thinking, seeing both the individual personality and the social-cultural context.

(Continued on page 62)

ARKANSAS MIDWIVES HAVE ALL-DAY GRADUATION EXERCISES

MAMIE O. HALE, R. N., *Certified Nurse Midwife, State Board of Health, Arkansas*

GRADUATION DAY is an event in anybody's life. To Arkansas midwives who have just completed a course in the basic principles of good maternity care it is a day of days.

The instruction is given by a nurse-midwife employed by the State board of health (the author of this article), who is loaned, on request, to county health departments to give a course lasting 8 to 12 weeks. (The sessions were described in *The Child* for October 1946.) Then comes Graduation Day, which is also a 1-day institute in midwifery—a summing up of the course just completed.

Planning the graduation requires much diplomacy on the part of the nurse-midwife and the local public-health nurse.

It is the midwives' own day

First there is the problem of getting the midwives themselves to agree on what community to hold it in, when to hold it, and, most important to them, in whose church. Each midwife would like it held in her own church because this would lend her prestige and give her an opportunity to be the "big hostess," or the "mainest hostess" for the event. Too, when the graduation exercises are held at a particular church or school, the minister of that church, or the principal or teacher of that school, is on the program to make welcoming remarks. Each midwife would like her preacher or teacher to have that honor. We try to leave it up to the midwives, as much as possible, to do the arranging for the graduating exercises (except the instructional part). They are made to feel that it is their day.

In planning for the locality where the exercises are to be held, the nurse-midwife tries to help the midwives to see the wisdom of selecting a community that can be reached easily by bus, and of selecting a church or school that will be large enough to accommodate the visitors, because this meeting is a public, county-wide one.

Usually each of the midwives wants to have somebody from her church sing, or recite, or just say a few words. But the time would not allow this, for in some counties we have as many as 80 or 90 midwives. And if one is allowed this privilege and another is not, it causes hard feelings.

In the Delta counties in Arkansas, where the Negro population is greatest, there are more midwives and more problems for the midwives, as well as for the nurse-midwife.

About three-fourths of the midwives in the Delta area live on plantations; so during the series of classes the midwife sometimes has difficulty in convincing her "boss man" that it is necessary to be away. And when it is time for the "big day," she wants to be sure that she will have no difficulty in getting off. Hence, she asks the nurse-midwife to give her a "strip" (letter of explanation about the meeting).

The nurse-midwife gets the names of all plantation owners in the county, every physician, teacher, registrar of vital statistics, and all key people in the county. Then each receives a letter of invitation from the county health department.

Letters of invitation to parents that a midwife has served are sent out through the midwives, with a notation on the letter that the graduating exercises are for adults only. This is necessary for two reasons. If this were not specified, parents would bring all their children, and children soon become restless and disturb the program. Also the church would be filled with children, who would get very little from the program, and the adults could not be properly seated.

Everybody brings lunch from home because there are never sufficient restaurant accommodations for such a large crowd. And the midwives and parents enjoy sharing their lunches with one another.

Midwife course summarized

At the graduating exercises a summary is given of the content of the 8 to 12 weeks of special instruction. Usually the local public-health nurse gives the objectives of the special course for midwives in the county. A local physician speaks on some phase of maternity care, such as "Danger signals in pregnancy," or some other subject taken up in the previous instructions. Consultants from the State board of health give talks on such subjects as nutrition, venereal disease, vital statistics, and general maternal and child health. A demonstration is given of the "modern midwife bag" (one equipped so as to meet the requirements of the State board

of health). The gathering then hears remarks from the midwives and from people in the community who have learned of the program. The main feature of the day is an address by the State board of health's maternal and child-health director, a woman physician, who presents the graduates with permits to practice. She also issues certificates of honorable retirement to midwives who are giving up practicing.

An important feature for the midwives and the visiting parents is the group-singing period; this usually takes about 5 or 10 minutes at some time during the morning and about the same length of time in the afternoon. We try to let the midwives select their own songs.

In her remarks the director quotes verses from the Bible with reference to midwives and explains the responsibilities of the midwives in such a simple manner that the midwives and the most illiterate visitors cannot help but understand and enjoy it.

Midwives take solemn pledge

At the close of her address to the midwives, the director has each midwife stand, raise her right hand, and solemnly repeat the midwife pledge:

To make out a birth certificate for every child (living or dead) that she delivers, before she leaves the home; and after a delivery, to send or take the certificate to her local registrar.

To put two drops of silver nitrate in each eye of every baby that she delivers, immediately after birth.

Not to give any medicine at all to a mother or baby unless ordered to by a doctor.

Not to make any vaginal or rectal examinations.

Not to go on a case when she has a cold or feels ill.

To attend only normal maternity cases.

To insist that all her patients have regular medical supervision, including a blood test.

Not to deliver a woman having her first baby, as such a woman should be delivered by a doctor.

To attend all midwife classes and conferences unless she is ill or on a delivery call.

To keep her bag clean and to have it completely equipped at all times.

To obey all regulations and instructions regarding supplies, technique, and care of patients, issued for midwives by the State board of health.

Receive permits to practice

After the director's address and the solemn pledge, each midwife who has successfully completed the course of training receives a permit to practice during the current year.

Honorable-retirement certificates are issued to midwives who have been holding permits and who will agree to practice no longer, because of any or all of the following: Age, physical condition, inability or unwillingness to attend the midwife classes, or inability to learn or follow the simple instructions given by the health department.

As each retiring midwife marches forward to receive her retirement certificate she "just must shake your hand"—that of the director, the nurse-midwife, and the public-health nurse. After that she expresses a few words of gratitude.

The nurse-midwife, who acts as master of ceremonies, sums up. She talks on the qualifications of a good midwife and explains briefly ways in which the community may be of help to the health department and the midwives.

She urges the following:

That the family not call a midwife who has stopped practicing because she no longer has a permit to practice and is not properly equipped to give adequate care.

That they be sure to notify the midwife at least 4 months before the expected time of delivery.

That they ask the midwife to show them her permit when they first contact her. (If she does not have one to show, they will know that she is violating the regulations of the State board of health.)

That they refuse to let a midwife care for a member of the family if she comes to the home without her midwife bag, because the things that are absolutely necessary for safe, clean care are in that bag.

That as soon as a woman finds out that she is pregnant she will go to the family doctor or notify the health department, and if she plans to have a doctor or midwife deliver her at home, she should make this arrangement before she reaches the fifth month of pregnancy.

That the family not ask, nor expect, the midwife to give any kind of medicine, because the midwife is not a doctor.

That they have a name ready for the baby before the mother goes into labor, because the midwife is required to make out the birth certificate at the time of delivery and she must have the baby's name so that she can complete the birth certificate at that time.

That they find out ahead of time how much the midwife is going to charge for her delivery service, and understand what the price agreement is among the midwives in the county. In Arkansas the average fee that the midwives charge is from $12 to $15. Families are asked to pay the amount agreed on, but to refuse to pay more.

That they not employ a midwife who offers to do the delivery for less than the stipulated amount.

That they demand that the midwife be clean and neat, and that she wash her hands frequently while on the case.

That they realize that a midwife is violating the law if she fails to use silver nitrate in the eyes of a newborn baby immediately after birth; also if she fails to make out a birth certificate.

After the nurse-midwife's remarks, about 30 minutes are allowed for questions, and questions of all kinds are asked. Spontaneous remarks and testimonies are offered by the ministers, parents, expectant mothers, mothers who have recently given birth to babies, and others.

So stimulated and appreciative are the people who visit us on Graduation Day that when we hold it for the first time in a county they always ask us to make it an annual affair.

For the prestige of trained midwives

The staff members who plan the affair feel that its value lies not only in reaching the people of the county and acquainting them with what the health department is teaching the midwives; the exercises also stress the responsibilities of the community and the midwives to each other. Most of all, Graduation Day helps to build up the prestige of the midwives who have successfully completed the course of training, and thus influences families to seek better maternity care.

Reprints available in about 3 weeks

TEEN-AGERS AT WORK

ELIZABETH S. JOHNSON, *Director Child Labor Branch*
Wage and Hour and Public Contracts Divisions, U. S. Department of Labor

WE in the United States like to think that practically all our teen-agers are preparing for full and successful lives by carrying their formal education at least through high school, and that many go on to college, or to vocational or technical schools, according to their individual interests and abilities. We know that many youngsters work during vacation or outside school hours, and we easily assume that they acquire useful experience in this way. We are reluctant, however, to admit that any large number of children are leaving school and entering full-time employment without the benefit of a full high-school course and to realize that they face the competition of occupational life seriously handicapped, vocationally or otherwise.

All over the country communities and organizations are looking forward to the Midcentury White House Conference for Children and Youth as a time for reassessing the needs of the younger generation and their own progress in meeting them. The inclusion of "youth" in the call for the conference makes it particularly appropriate to consider anew what can be done for all boys and girls not only to improve safeguards against exploitative child labor but also to afford opportunities leading to vocational satisfaction, as these are important aspects of any rounded program of services for young people.

From school to work

Broadly speaking, we may say that in the child-labor and youth-employment field we are concerned with preventing employment of children at too early an age, with helping children to continue in school, with safeguarding the conditions under which they are permitted to go to work when the time comes, with improving standards of employment, and with stimulating planning and support for guidance, counseling and placement services. These services aim to facilitate the transition of young people from school to work and increase the vocational satisfactions they will receive through their work.

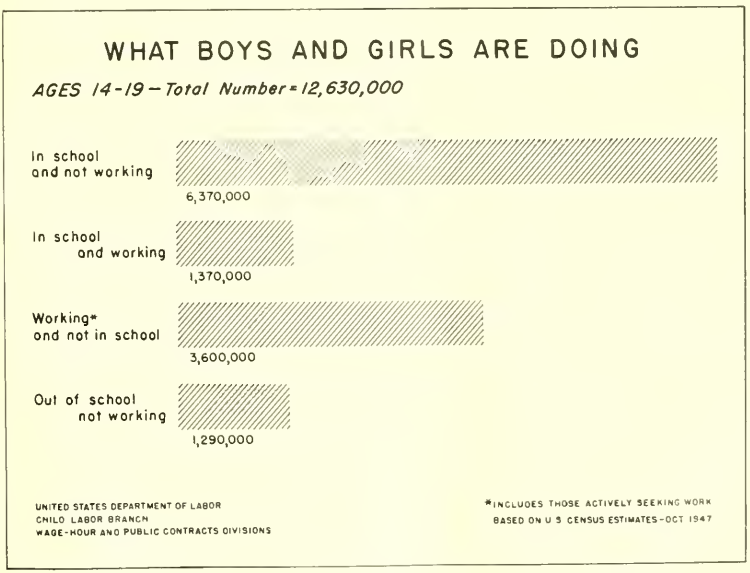
To cope successfully with these problems we must understand what is happening to individual youngsters leaving school for work; we must study the ways communities have found of meeting the employment needs of young people; and we must know the score—the school-attendance vs. child-employment score—for the Nation as a whole.

In the United States population 14 through 19 years of age—the group of young people who were in the lower grades of elementary school when the 1940 White House Conference was held—we find roughly 8 million boys and girls in school and 5 million out of school in the fall of 1947. Of the 5 million out of school, more than 3½ million were employed (chart I). Among those 16 and 17 years of age a third, or 1,400,000, were out of school, and even among children of 14 and 15 nearly one-tenth (350,000) were out of school (chart II).

Both these charts, based on estimates of the United States Bureau of the Census for October 1947, separate young people of the ages shown into four categories: (1) those attending school and not working; (2) those attending school and also working; (3) those working and not going to school; and (4) those who are neither attending school nor working. In every case "working" is equivalent to the census phrase "in the labor force"; that is, working or actively looking for work. Young workers who were unemployed at the time of the census therefore are shown as "working," and only those who for some reason are not currently in the labor force are counted as "not working." To get the entire number in any age group who were in school, it is necessary to add the first two categories; to get the entire number working either full time or part time, it is necessary to add the second and third categories.

One point of especial interest is the number of students working part time—more than a million of them, 14 through 17 years of age. The greater prevalence of part-time employment among high-school boys and girls is perhaps the most notable change in the volume of employment of minors under 18 compared with that in 1940. The 1940 figures, of course, still reflected depression conditions in youth employment, although rising standards of child-

CHART 1



labor protection and school attendance were also a factor in the declining level of youth employment during the 1930's.

Emphasis on part-time employment of students as an alternative to leaving school for full-time employment was one of the features of the wartime National Back-to-School drives sponsored by the Children's Bureau and the Office of Education. The increasing ratio of part-time to full-time employment at the high-school age, although it is probably a good sign, gives rise to the need for some new emphases on child-labor regulation and on services to young persons in the transition from school to work.

Tangible vs. intangible values

Children who attempt to carry a job in addition to attending school often find that the double load deprives them of rest and recreation or that their grades suffer. Too often they are tempted to give up school with its intangible values rather than sacrifice the job with the very tangible pay envelope to which they have become used.

This situation presents a challenge to States and communities to see that the right kind of controls and supervision over part-time and vacation employment are developed, and that the experience gained in part-time jobs is utilized to the greatest degree possible in the vocational planning of young people. At least one State (New York) has recently enacted a law to regulate combined hours of school and work for young people 16 and 17 years of age.

At present the level of youth employment, both full time and part time, is probably higher than it should be for youth under 18, and especially boys and girls under 16.

The wartime upward swing in employment of young people, both full time and part time, is shown in chart III. In April 1945, just before the war ended, but after the wartime boom in youth employment had slowed down to some extent, the number of young workers 14 through 17 years of age was estimated at 3,400,000 by the Bureau of the Census. With the close of the war the number of young workers dropped rapidly and then leveled off at about 2,000,000, which is nearly twice the 1940 figure. In April 1948 it was slightly more than 2,000,000. The April figures represent employment of boys and girls during the school year. In July, when summer vacation employment hits a peak, the total runs one-half to two-thirds above the April or October figure.

Meanwhile the percentage of all boys and girls 14 through 17 years of age reported by the United States Bureau of the Census as enrolled in school—roughly speaking, the high-school group—was increasing after its wartime slump, and by 1947 was again approaching the 1940 level.

Even more important, numerically, than part-time employment, is withdrawal from school and entry into the full-time labor market. Altogether, more than 3½ million young people 14 through 19 years of age are already out of school and in full-time employment. To the extent that this group includes children of 14 or 15, or older boys and girls who have not completed high school, serious questions are raised. Why do these youngsters drop out of school? How do they go about looking for work? What kind of jobs do they find? And how well do they succeed in adjusting themselves to the working world?

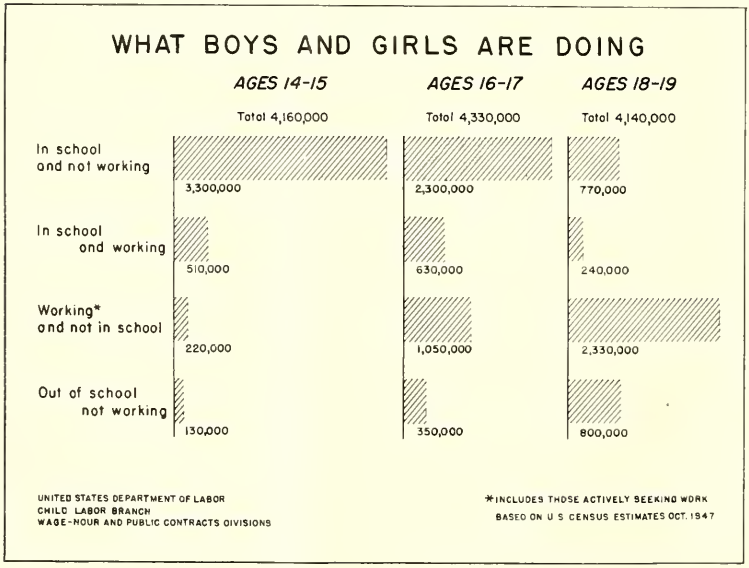
To obtain first-hand knowledge about what is happening to boys and girls who drop out of school, the child-labor staff of the United States Department of Labor undertook a study of youth-employment problems in 1947. As part of this project 524 young people 14 through 19 years of age were interviewed in Louisville, Ky., which had been selected as a representative American city. All these young people were out of school and in the labor market. At that time it was legal, in Kentucky, for children to leave school for work at the age of 14; in 1948 the legal minimum age was raised to 16 years.

Many jobless young people

A surprising number of boys and girls, though in the labor market, were unemployed: 46 percent of the 14- and 15-year-old children, 36 percent of the 16- and 17-year-olds, and 21 percent of the 18- and 19-year-olds. Chart IV shows the employment status of these Louisville young people, by 2-year age groups. The younger the children, the more likely they were to be without work—very nearly half of those under 16 had no job. Although we do not like to think of 14- and 15-year-old children as "unemployed," these children are so reported because they were out of school and looking for jobs, and because most of them could legally be out of school only if employed.

Inability to find jobs or to keep the jobs they found was a keenly felt difficulty with many of the Louisville young people. Two out of three of those who

CHART 2



were unemployed at the time of the study had been job-hunting for at least a month; one in five had been without regular employment for 6 months or longer. Half of them said their previous job had lasted less than 3 months. In general their idea of looking for work was to follow up help-wanted ads in the newspaper, ask friends and relatives, or apply directly to employers. Very few—less than 3 percent of those reporting—had obtained their last or current job through the local office of the State employment service, and the majority had never heard of it.

"Some one else always gets there first," said one youngster in trying to account for his failure to find a job. "Until you're 16, no one wants to hire you," said a number. "I can't get the kind of job I want without more education," was the conclusion others had reached.

Employers who were interviewed in the course of the study said that boys and girls under 18 were likely to be immature, undependable, and unstable psychologically; and unequal to maintaining high-speed output, physically. Many employers said they preferred high-school graduates because they seemed to have a better general background, greater capacity to keep up an even speed, and were more likely to get along with fellow workers.

That education has a cash value on the job is shown by a recent unpublished survey of the earnings of urban and nonfarm workers in the United States. A clear correlation appears between educational level and salary. As estimated by the Bureau of the Census for April 1947, in the age group 25 to 44 years, the median annual earnings of workers who had completed only grammar school were $1,806; of those who had completed high school $2,005; of those who had one year or more at college, $2,403. In the age group 45 to 64 years of age, when most workers reach their peak earnings, the spread was even greater—from $2,097 to $2,945.

An analysis of the earnings of 443 Louisville boys and girls showed that half of them earned more than 60 cents an hour on their current or last job; half earned 60 cents or less. The median hourly wage rate for the youngest workers, however, was only 48 cents an hour, compared with 71 cents for the 18- and 19-year-olds. In manufacturing establishments, more than four-fifths of those reporting hourly earnings earned 60 cents or more. For manufacturing and also for transportation (and two-fifths of the young workers, most of them boys and girls in the older age groups, were in some branch of these industries) the median hourly wage rate reported was more than 75 cents an hour.

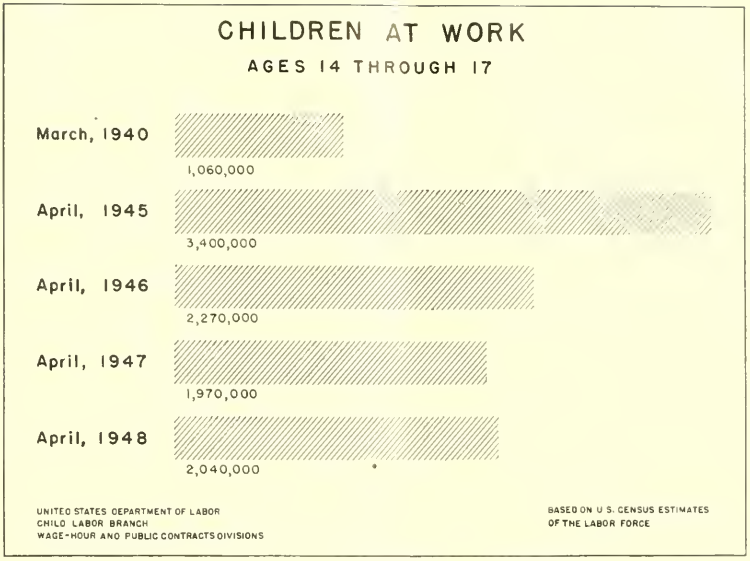


CHART 3

Children out of school at 14 or 15 years of age had little choice of jobs, to judge from an analysis of the last job they had held or their current job at time of interview. Their jobs lasted fewer months on the average and their rate of turnover was higher than among the young people of 16 and over. Most of the illegal employment found was in this group. In many cases they worked longer hours than did older boys and girls in better standardized occupations.

Youngest workers get poorest jobs

Half of the jobs held by the children 14 and 15 years of age were in retail trade—for the most part in 5- and 10-cent stores, grocery stores, and restaurants; and nearly one-third were in service industries—laundries, hospitals, or domestic work in private homes. These are all types of work in which overlong hours and undesirable conditions of work are frequently found.

In contrast, 35 percent of the employed minors 16 and 17 years of age were in manufacturing; 29 percent in trade; and about 20 percent in the service industries.

Except in the oldest group, few of these young people had completed high school before starting their working careers. Two-thirds of those who were under 18 had left school without completing more than the eighth grade. The reason most frequently given for not going through high school was dissatisfaction with some aspect of school life. As they explained it, they could not take the particular course they wanted, or had fallen behind in their grades, or felt the teachers were not sufficiently interested in them as individuals. Next most frequent as a reason for leaving school was lack of money, either in the form of pressure to contribute to the family income or as lack of funds for books, lunches, carfare, and other school essentials. Often both dissatisfaction with school and economic pressure were factors in the decision to drop out of school. Some youngsters wanted the independence or the prestige they associated with working. A number dropped out because of physical defects or ill health (and, in the case of girls, of pregnancy), or because of illness in the family, and there were other scattered reasons.

Ironically, young people who cut short their education because of eco-

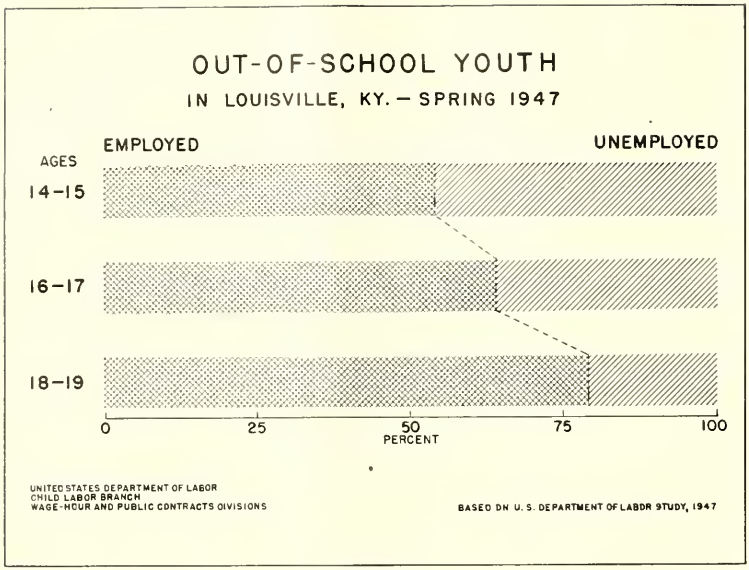


CHART 4

nomic pressure are likely to find, too late, that their earning capacity throughout life is limited by their lack of training. Some of the youngsters in the Louisville study had already discovered that they could not qualify for the type of job they aspired to—auto mechanic, nurse, lawyer, or foreign-language translator—without more education.

With inadequate educational preparation and little or no guidance into work suited to their abilities, few of the Louisville young people under 16 were finding real vocational satisfaction in their work. Only about one in four, as a matter of fact, was well satisfied with the type of work he was doing, and one in three was actually unhappy in his job. Those in the 18- and 19-year-old group, who had either more education to start with or a longer time in which to fumble toward congenial work by the trial and error method, were on the whole better content with the type of work they were doing. But even in this age group only two in five seemed to feel a keen satisfaction in their jobs, and one in four was markedly dissatisfied with the kind of work he was in.

Young people who have neither interest in nor aptitude for the work they are doing are not likely to succeed very well in their jobs. As a result, few jobs except those of a routine nature or those unattractive to better-qualified workers are open to youngsters. The boy or girl, therefore, who either from choice or necessity drops out of school for work has to struggle with the double handicap of poor qualifications and restricted job opportunities.

So long as any large number of children leave school and enter occupational life without the maturity, personal qualifications, and educational background on which to build a successful working career, the implications are grave indeed in terms of both community and national welfare. But this is just what is happening, if the findings of the Louisville study in regard to out-of-school youth can be accepted as typical—and I believe that in their broad outlines they can be.

Even in the present period of relatively full employment, youngsters who leave school before completing high school are likely to experience difficulty in finding satisfactory jobs. They are cut adrift from their familiar world of school, needing an income but experiencing the insecurity of the marginal worker who is often unemployed and usually unsure of his job. Under these circumstances it would be remarkable if some of them did not become lazy, restless, baffled, or discouraged. These are seldom the young people who come in contact with the counseling and guidance services available in many of the State employment offices and through youth-serving organizations. They are the ones whose needs have too often gone unnoticed by both public and private agencies. How to find them and bring them encouragement and the guidance and placement services or the additional education and training which will develop their abilities—these are problems for community leadership.

Clearly, it is to the interest of communities to do everything in their power to improve the qualifications of young job seekers through education and training. Cooperation of both employers and organized labor, as well as youth-serving organizations, is essential in carrying out community planning for services to boys and girls entering employment and in providing worthwhile job opportunities under good working conditions for young workers.

Many communities (including Louisville, which has organized a citizens' youth employment committee) are already planning and instituting measures to insure their young people the kind of start they need.

The basic requirement—through which much of this waste of human resources can be avoided—is for improved and diversified *educational facilities* which will hold the interest of young people past the point at which they can legally leave school for work. Closely allied with this is the provision of *student aid* and other financial measures to enable children in families of limited income to take advantage of educational opportunities to the full. These measures must be underpinned by *legal protection* against employment of children contrary to accepted standards. The effectiveness of child-labor laws, in turn, depends on local understanding and cooperation, a spirit of compliance, and strong enforcement.

Building from this solid foundation, *guidance and placement services* can aid the vocational planning of boys and girls and facilitate their transition from school to work at the proper time. Such services repay a community richly through the vocational satisfactions its young people enjoy and through the increased contributions they are able to make to the common welfare.

Reprints available in about 3 weeks

NEW MCH-CC ADVISORY COMMITTEE MEETS

A new advisory committee to the Children's Bureau on Federal-State programs for maternal and child health and crippled children's services met in Washington, D. C., September 14–15, 1948.

Invited by the Children's Bureau to advise it on matters of public policy affecting the promotion of better health for mothers and children, this new committee is the first in the child-health field with representation both of nonprofessional and professional groups, to be given this broad mandate. Dr. Harry H. Gordon, Professor of Pediatrics, University of Colorado Medical Center, was elected chairman of the committee for 3 years.

Members include (1) designated representatives of medical, nursing, hospital, dental, medical social work, physical-therapy, and dietetic associations; (2) representatives of voluntary health agencies; (3) leaders in labor, farm, women's, and veterans' groups; (4) specialists from graduate schools of medicine and allied sciences; and other distinguished citizens.

The committee devoted much of its time at this first organizing meeting to becoming acquainted with the Children's Bureau's work in the fields of maternal and child health and crippled children's services. Pointing to the tremendous shortage of all kinds of professional personnel in child health, the committee discussed at length ways and means of stimulating the training of more professional workers and auxiliary personnel for the maternal and child-health programs and reviewed the way the State health agencies are now working with universities to this end. The Children's Bureau reported that the existing limitations on the total available funds restrict the amount of work that can be undertaken to expand opportunities for professional education.

Closer teamwork and understanding between nongovernmental and governmental agencies working to improve child health, the committee stressed, should be developed. To this end, the Children's Bureau was encouraged to set up an information exchange on programs and projects of such agencies as a first step toward better over-all planning by voluntary groups and Government in behalf of children and mothers.

Better care for more children, particularly for those of school age and for those with seriously crippling conditions, was accepted as a goal by the committee without arriving at any specific recommendations.

The Children's Bureau is responsible for administering the $18,500,000 grants which the Congress makes available each year to the States to "extend and improve" their maternal and child-health services and services to crippled children. Under these State maternal and child-health programs, many kinds of services operate for the promotion of health and a more limited range of services for the treatment of sick mothers and children. State programs for crippled children attempt, within their resources, to provide for diagnosis and treatment as needed.

In welcoming the members of the new Advisory Committee at their first meeting, Dr. Martha M. Eliot, Associate Chief of the Children's Bureau, emphasized the wide opportunities of the group to help in molding public policies in respect to the development of these programs.

"The Congress has laid down broad rules within which Federal aid can be given. Within that area, the Children's Bureau must make many policy decisions as to which services are most needed; how they can be provided effectively; what help health workers and agencies need in providing services. On such questions as these," Dr. Eliot said, "we want the benefit of your counsel as to what is in the best interest of mothers and children. The door is wide open to you, as spokesmen for the purveyors and consumers of health services, to tell us what we ought to do and how we ought to move—always within the authority given us by the Congress."

The committee recommended that meetings be called by the Children's Bureau at least twice a year.

The members of the Advisory Committee on Maternal and Child Health and Crippled Children's Services, appointed by the Chief of the Children's Bureau, July 1948, for a 3-year term, are:

Raymond B. Allen, M. D., University of Washington, Seattle, Wash. President, University of Washington.

Abraham Barhash, M. D., 1790 Broadway, New York, N. Y. Director, Division on Community Clinics, National Committee for Mental Health. Representing National Committee for Mental Health.

Harriett M. Bartlett, 51 Commonwealth Ave., Boston 16, Mass. Associate Professor of Social Economy, School of Social Work, Simmons College.

W. W. Bauer, M. D., 535 North Dearborn St., Chicago 10, Ill. Director, Bureau of Health Education, American Medical Association. Representing American Medical Association.

George Bugbee, 18 East Division St., Chicago 10, Ill. Executive Director, American Hospital Association. Representing American Hospital Association.

Allan M. Butler, M. D., Massachusetts General Hospital, Fruit St., Boston 14, Mass. Professor of Pediatrics, Harvard Medical School.

Dean A. Clark, M. D., 425 Avenue of the Americas, New York 11, N. Y. Director, Health Insurance Plan of Greater New York.

Hazel Corbin, R. N., 654 Madison Ave., New York 21, N. Y. General Director, Maternity Center Association. Representing Maternity Center Association.

William J. Darby, M. D., Vanderbilt University, Nashville 4, Tenn. Departments of Medicine and Biochemistry, School of Medicine, Vanderbilt University.

M. Edward Davis, M. D., University of Chicago, Chicago, Ill. Professor of Obstetrics and Gynecology, School of Medicine, University of Chicago.

Claudia Durham, R. N., Meharry Medical College, Nashville, Tenn. Associate Professor of Nursing, Meharry Medical College.

Kenneth A. Easlick, D. D. S., University of Michigan, Ann Arbor, Mich. Professor of Dentistry, School of Dentistry, University of Michigan. Representing American Dental Association.

Nicholson J. Eastman, M. D., Johns Hopkins Hospital, Baltimore 5, Md. Professor of Obstetrics, School of Medicine, Johns Hopkins University.

Mrs. Lulu Evanson, North Dakota Farmers Union, Jamestown, N. Dak. Director of Education, North Dakota Farmers Union. Representing National Farmers Union.

Katharine Faville, R. N., Wayne University, Detroit, Mich. Dean, College of Nursing, Wayne University.

Charles F. Good, M. D., County Health Department, Cleveland, Ohio. Directing Supervisor, Health Service, Board of Education.

Harry H. Gordon, M. D., University of Colorado, Denver, Colo. Professor of Pediatrics, School of Medicine, University of Colorado.

William T. Green, M. D., 300 Longwood Ave., Boston 15, Mass. Orthopaedic Surgeon, Children's Hospital, Boston. Representing American Academy of Orthopaedic Surgeons.

John P. Hubbard, M. D., Children's Hospital, 1740 Bainbridge St., Philadelphia, Pa. Executive Secretary, Committee for the Improvement of Child Health, American Academy of Pediatrics.

Herbert R. Kobes, M. D., 1105 South Sixth St., Springfield, Ill. Director, Division of Services for Crippled Children, University of Illinois.

Lawrence J. Linck, 11 South LaSalle St., Chicago 3, Ill. Executive Director, the National Society for Crippled Children and Adults. Representing National Society for Crippled Children and Adults.

William Mengert, M. D., 2211 Oak Lawn Ave., Dallas 4, Tex. Professor of Obstetrics and Gynecology, Southwestern Medical College, Dallas. Representing National Federation of Obstetric-Gynecologic Societies.

James Raglan Miller, M. D., 179 Allyn St., Hartford, Conn. Trustee, American Medical Association. Representing American Medical Association.

Oscar L. Miller, M. D., 121 West Seventh St., Charlotte 2, N. C. Orthopaedic Surgeon, Miller Orthopaedic Clinic.

Mary Blanche Moss, 1129 Vermont Ave. NW., Washington 5, D. C. Executive Secretary, American Association of Medical Social Workers. Representing American Association of Medical Social Workers.

Ewell Newman, 1133 Broadway, New York 10, N. Y. Social Case Work Consultant, National Urban League. Representing National Urban League.

Harry A. Ong, M. D., 1801 I St. NW., Washington 6, D. C. Representing American Academy of Pediatrics.

Grover F. Powers, M. D., Professor of Pediatrics, Yale University School of Medicine, New Haven, Conn.

John Z. Preston, M. D., Tryon, N. C. General medical practice.

Harry Read, 718 Jackson Pl. NW., Washington 6, D. C. Executive Assistant to the Secretary-Treasurer, Congress of Industrial Organizations. Representing Congress of Industrial Organizations.

Duncan E. Reid, M. D., 221 Longwood Ave., Boston 15, Mass. Professor of Obstetrics, Harvard Medical School.

Raymond T. Rich, 30 E. 22d St., New York 10, N. Y. Chairman, Raymond Rich Associates.

Hugh B. Robins, M. D., Marshall, Mich. Director, Calhoun County Health Department.

Edward S. Rogers, M. D., University of California, Berkeley, Calif. Dean, School of Public Health, University of California.

Thomas E. Shaffer, M. D., Ohio State University, Columbus 10, Ohio. School Physician, University School, Ohio State University. Representing American School Health Association.

Randel Shake, 777 N. Meridian St., Indianapolis 6, Ind. Assistant Director, National Child Welfare Division, American Legion. Representing American Legion.

Catherine E. Sheckler, R. N., 5733 University Ave., Chicago 37, Ill. Assistant Professor, Nursing Education, University of Chicago. Representing American Nurses' Association.

Nathan Sinai, D. P. H., University of Michigan, Ann Arbor, Mich. Professor of Public Health, School of Public Health, University of Michigan.

Ernest Stebbins, M. D., Johns Hopkins University, Baltimore, Md. Director, School of Hygiene and Public Health, Johns Hopkins University.

Florence C. Thorne, 901 Massachusetts Ave. NW., Washington, D. C. Director of Research, American Federation of Labor. Representing American Federation of Labor.

Felix J. Underwood, M. D., Jackson 113, Miss. Executive Officer, Mississippi State Board of Health.

Abram L. Van Horn, M. D., 744 Broad Street, Newark, N. J. Medical Director, Kate Macy Ladd Fund. Representing American Public Health Association.

R. M. Walls, D. D. S., Bethlehem, Pa. Dental practitioner.

Mrs. Roy C. F. Weagly, Rural Route No. 1, Hagerstown, Md. President, Associated Women, American Farm Bureau Federation. Representing American Farm Bureau Federation.

Barbara White, 1790 Broadway, New York 19, N. Y. Educational Secretary, American Physiotherapy Association. Representing American Physiotherapy Association.

James L. Wilson, M. D., University of Michigan, Ann Arbor, Mich. Professor, Department of Pediatrics and Communicable Diseases, School of Medicine, University of Michigan.

Mrs. Eva Ylvisaker, Children's Hospital, Cincinnati 29, Ohio. Chief Dietitian, Children's Hospital. Representing American Dietetic Association.

Still to be appointed are a representative of the National Congress of Parents and Teachers, a representative of the General Federation of Women's Clubs, and a representative of the American Association of University Women.

We Organize a Clearinghouse for Research in Child Life

CLARA E. COUNCELL
Director, Clearinghouse, Children's Bureau

The first meeting of the Advisory Committee of the Children's Bureau Clearinghouse for Research in Child Life was held in Washington on September 11, 1948, to launch the organization of this service. The clearinghouse is being established at the request of scientists who feel the need for a center that will promote collaboration and interchange of information on current research in the various fields affecting child life. Moreover, the Children's Bureau, as the Federal agency authorized to "investigate and report . . . upon all matters pertaining to the welfare of children and child life . . ." needs an over-all view of on-going research in order to study the question of how existing activities may be supplemented and extended.

This clearinghouse is a mechanism to collect from and distribute to research workers information about on-going investigations that directly affect children and mothers. Its main purpose is to help to keep scientists informed about such studies in progress that have not been fully described in publications, and to bridge the time-gap between completion and published report of these research projects.

The recommendation that the Children's Bureau establish a clearinghouse grew out of a series of research conferences which the Children's Bureau has held during the past year to review what is going on in research in child life, what the gaps are, and how the needs for research can be met. The following representatives of many fields participated in one or more of these conferences:

Dr. C. Anderson Aldrich, Director, Rochester Child Health Project, Mayo Clinic.

Mr. Herschel Alt, Executive Director, Jewish Board of Guardians, New York City.

Dr. John E. Anderson, Director, Institute of Child Welfare, University of Minnesota. (Member of Children's Bureau Clearinghouse Advisory Committee.)

Dr. Allan M. Butler, Professor of Pediatrics, Harvard University Medical School.

Dr. Allison Davis, Professor of Education, University of Chicago.

Dr. Sibylle K. Escalona, as Clinical Psychologist, Menninger Foundation.

Mr. Lawrence K. Frank, Director, Caroline Zachry Institute of Human Development.

Dr. E. Franklin Frazier, Head, Department of Sociology, Howard University.

Dr. Frank Fremont-Smith, Medical Director, Josiah Macy, Jr., Foundation.

Mr. David G. French, Assistant Executive Secretary, American Association of Social Workers. (Member of Children's Bureau Clearinghouse Advisory Committee.)

Mr. Donald S. Howard, as Director, Department of Social Work Administration, Russell Sage Foundation.

Dr. John P. Hubbard, as Director, American Academy of Pediatrics Study of Child Health Services.

Dr. Arthur T. Jersild, Professor of Education, Teachers College, Columbia University.

Dr. Mary Cover Jones, Research Associate, Institute of Child Welfare, University of California.

Dr. Clyde Kluckhohn, Professor of Anthropology, Harvard University.

Dr. Mary Fisher Langmuir, Chairman, Department of Child Study, Vassar College.

Dr. Samuel Z. Levine, Professor of Pediatrics, Cornell University Medical College.

Dr. David M. Levy, Child Psychiatrist, New York City.

Dr. Willard C. Olson, Director of Research in Child Development, School of Education, University of Michigan. (Member of Children's Bureau Clearinghouse Advisory Committee.)

Dr. Marian C. Putnam, Director, Children's Center, Roxbury, Mass.

Dr. Marian Radke, Research Center for Group Dynamics, Massachusetts Institute of Technology.

Dr. Milton J. E. Senn, Associate Professor of Pediatrics in Psychiatry, Cornell University Medical College.

Dr. Alfred H. Washburn, Director, Child Research Council, University of Colorado School of Medicine.

Dr. John W. M. Whiting, Cniversity of Iowa Child Welfare Research Station. (Member of Children's Bureau Clearinghouse Advisory Committee.)

Dr. James L. Wilson, Chairman, Department of Pediatrics and Communicable Diseases, University of Michigan.

Dr. Irving J. Wolman, Assistant Professor of Pediatrics, University of Pennsylvania Medical School. (Member of Children's Bureau Clearinghouse Advisory Committee.)

Dr. Helen R. Wright, Dean, School of Social Service Administration, University of Chicago.

Dr. Donald R. Young, as Executive Director, Social Science Research Council

These advisers have recommended that the Children's Bureau develop a center for information about projects pertaining to children and mothers, being undertaken by one or more of the various disciplines. Information on such research in progress is nowhere available in one spot, and investigators have agreed that the availability of such information would encourage more cooperative planning on research in child life. The value of the clearinghouse will be dependent upon its scope and coverage. It can be a communicating device between research workers in different specialties. The clearinghouse is being organized to help answer questions basic for cooperative planning, such as, What research is now going on, inside and outside of the Federal Government, that affects children and

(Continued on page 62)

Mental Health

(Continued from page 52)

All this has an immediate bearing upon the field of child welfare because it reemphasizes what has been said, and frequently attempted, by workers in this field—namely, that for constructive achievement, we must learn how to work together more efficiently and cooperatively. We must learn how to communicate between disciplines, especially to recognize each other's contributions to the understanding of this problem of the individual and society. We must learn that we cannot get very far by purely individual clinical methods nor by large-scale administrative, legal, or legislative arrangements, but that we can go forward more rapidly and effectively by learning to make the clinical work reveal the urgent needs and promising opportunities for the large-scale approach and make the large-scale statistical studies disclose the underlying clinical problems and the opportunities for prevention.

Above all, the clinical, the administrative, and the research groups should recognize their interdependence and greatly enlarged potentialities if they can and will work together, using the concept of the dynamic personality process and of the social institutional operations for meeting the exigent problems of human development.

Finally it should be reemphasized that if we want to foster mental health from infancy on, we must communicate the new knowledge of human growth and development, the new insights into personality development, the new understanding of the child's needs for love and security to parents who are the primary guardians of mental health.

The congress specifically recognized the large number of children who have been deprived of parental care and who today are urgently in need of help and whatever we can provide as partial replacement of family life.

When we recognize that social life is that which is maintained by all members of a group, we will realize that child welfare is not a sentimental program but the basic approach to desirable social order and human advance because no one, no matter how insignificant or unimportant he may seem to be, can be neglected, unnecessarily deprived or frustrated, maltreated or humiliated. Everyone so treated will by so much be less capable of contributing to social order, less capable of respecting others, because he cannot maintain peace and order in himself nor respect himself.

Mental health, as it is conceived today and notably as formulated at the congress, now appears as commensurate with the whole of human life, the latest expression of our enduring values and traditional aspirations toward the value of the human personality, toward respect for the dignity of man, woman, and child.

Through the newly organized World Federation for Mental Health, working closely with the World Health Organization and UNESCO, it should be possible for those who are concerned with children in every country to cooperate, sharing ideas and techniques and ever more surely beginning to conserve, guide, and protect children, who are the living expression of a culture and the active agents of society.

Reprints available in about 3 weeks

Clearinghouse

(Continued from page 61)

mothers? On what aspects of child growth and development and of family and community life is research most needed in relation to children?

Research workers will be asked to prepare their own brief descriptive statements about projects and will, of course, not be expected to give results or conclusions except as may be desired by the research worker himself. The participation of research workers will be voluntary but it is hoped that cooperation will be extensive. The clearinghouse will canvass investigators in various fields for reports on studies in progress and will release a bulletin in 1949 to inform scientists and a restricted group of authorized agencies and organizations about current investigations relating to child life. In addition, the clearinghouse will provide information to research workers upon request.

Queries with regard to the clearinghouse may be addressed to Clearinghouse, Children's Bureau, Federal Security Agency, Washington 25, D. C.

Reprints available in about 3 weeks

• IN THE NEWS

UNICEF Issues Newsletter

The United Nations International Children's Emergency Fund is issuing a newsletter, reporting on the activities of the Fund in many parts of the world, both in the countries that are contributing supplies to the Fund and those that are receiving help for their children.

In its announcement UNICEF expresses the hope that its newsletter will be widely used in many countries to acquaint people generally with the work of the Fund, and, in particular, those who have included an active part in it. Among the workers taking an active part are many who are volunteering their help as well as those who are working in an official capacity.

Copies of the newsletter are available free upon request to the United Nations International Children's Emergency Fund, 405 East Forty-second Street, New York 17, N. Y.

Kentucky and Virginia Pass New, Improved Child-Labor Laws

New child-labor laws enacted this year in Kentucky and Virginia materially raise standards in these States for employed children and young persons.

Both acts widen the occupational coverage of the former laws, raise the minimum age for general employment, improve hours of labor and certificate standards, and strengthen the protection given young people from work in hazardous occupations.

The new acts bring the State minimum-age standards into line with the child-labor provisions of the Fair Labor Standards Act for establishments producing goods for shipment in interstate commerce.

SOURCE: *Labor Information Bulletin, U. S. Department of Labor, July 1948.*

Study Mental-Health Programs

Sponsored by the California Department of Public Health and the Commonwealth Fund, an institute on mental health was held at Berkeley, Calif., July 5–17, for 30 local health officers and State health-department personnel. The 16 members of the faculty of the institute represented the fields of pub-

lic-health administration, psychiatry, and pediatrics-in-psychiatry. One of the conclusions reached by the group was that mental-health programs in local areas need to be built around the mother-child relationship, with concentration at the start on education in mental health for all professional workers taking part in the program.

Child-Labor Certificates Approved for 43 States

Through cooperative agreements with the United States Department of Labor, age, employment, or working certificates issued by State agencies in 43 States, the District of Columbia, and Hawaii continued for the year beginning July 1, 1948, to have the same force and effect as Federal certificates of age under the Fair Labor Standards Act.

A regulation signed on June 28 by John T. Kmetz, then Acting Secretary of Labor, designates the States in which State certificates are acceptable as proof of age by the Wage and Hour and Public Contracts Divisions in enforcing the child-labor provisions of the act, which set a general minimum age of 16 years. Such designations have been made annually since 1938.

In the five States not included in the agreement—Idaho, Mississippi, South Carolina, Texas, and Washington—Federal certificates of age are issued by the Wage and Hour and Public Contracts Divisions. These States do not have certification systems, or do not issue certificates that can be used to prove age under the provisions of the Fair Labor Standards Act.

According to the Child Labor Branch of the Divisions, reports from 39 States, 30 cities in 2 other States, the District of Columbia, Hawaii, and Puerto Rico indicate that about 700,000 boys and girls 14 through 17 were issued employment or age certificates during 1947 for their first regular jobs or their first vacation or outside-school-hours jobs.

SOURCE: *Labor Information Bulletin, U. S. Department of Labor, August 1948.*

• FOR YOUR BOOKSHELF

A limited quantity of each of the following items, reprinted by the Children's Bureau from sources outside the Bureau, is available for distribution. Single copies may be had without charge.

Child Feeding in Europe Under the International Children's Emergency Fund. By Martha M. Eliot, M. D. *American Journal of Public Health*, January 1948.

Epidemic Diarrhea of the Newborn in Massachusetts; a 10-year survey. By A. Daniel Rubenstein, M. D., and George E. Foley. *New England Journal of Medicine*, January 16, 1947.

It Takes Hard Work; good social-work interpreters are made—not born. By Frances Schmidt. *Channels*, November 1947.

Public Relations in '48. By Sallie E. Bright. *Channels*. December 1947.

University Affiliation With Health Departments for Developmental and Educational Purposes. By W. A. McIntosh, M. D. *Canadian Journal of Public Health*, October 1947.

SOME SPECIAL PROBLEMS OF CHILDREN AGED 2 TO 5 YEARS, by Nina Ridenour in collaboration with Isabel Johnson. Drawings by Barbara Cooney. Eight leaflets. New York City Committee on Mental Hygiene of the State Charities Aid Association, 105 East Twenty-second Street, New York 10, N. Y. 1947. Separate leaflets 10 cents each; packet of eight, 75 cents. Discount on quantities.

This series of leaflets, designed for parents, is highly recommended to all who deal with parents or children, and especially for anyone who answers mothers' questions. The advice is presented simply and concisely and is in line with our present knowledge. The range of subjects represents accurately the problems mothers most frequently complain about. Physicians who lecture to mothers' groups should find the leaflets useful.

The titles of the leaflets are: (1) When a Child Hurts Other Children; (2) When a Child Is Destructive; (3) When a Child Uses Bad Language; (4) When a Child Won't Share; (5) When a Child Still Sucks His Thumb; (6) When a Child Still Wets; (7) When a Child Masturbates; and (8) When a Child Has Fears.

—Henry H. Work, M. D.

TOWARD A 1950 WHITE HOUSE CONFERENCE ON CHILDREN AND YOUTH; suggestions for State and local action, developed by Conference on State Planning for Children and Youth. Federal Security Agency, Social Security Administration, Children's Bureau. Washington, 1948. 20 pp. Processed. Single copies free.

The conference at which these suggestions were made for State and local activities leading toward a national conference on children and youth in 1950 was called by the Children's Bureau in cooperation with the National Commission on Children and Youth, March 30–April 1, 1948. A preliminary statement of these suggestions, condensed, was published in *The Child* in its May 1948 issue.

• CALENDAR

Oct 21–22—National Committee on Homemaker Service. Annual meeting. New York, N. Y.

Oct. 24—United Nations Day.

Nov. 3–4—National Committee for Mental Hygiene. Thirty-ninth annual meeting. New York, N. Y.

Nov. 7–13—American Education Week. Twenty-eighth annual observance. Further information from National Education Association of the United States, 1201 Sixteenth Street NW., Washington 6, D. C.

Nov. 8–12—American Public Health Association. Seventy-sixth annual meeting. Boston, Mass.

Nov. 13—Association of Maternal and Child Health and Crippled Children's Directors; with the Children's Bureau. Washington, D. C.

Nov. 14—Association of State and Territorial Health Officers and the Association of Maternal and Child Health and Crippled Children's Directors; with the Children's Bureau. Washington, D. C.

Nov. 14–20—Children's Book Week. Twenty-ninth national observance. Further information from Children's Book Council, 62 West Forty-fifth Street, New York 19, N. Y.

Nov. 15–17—National Society for Crippled Children and Adults. Annual convention. Chicago, Ill.

Nov. 17—Association of State and Territorial Health Officers; with the Public Health Service and the Children's Bureau. Washington, D. C.

Nov. 18–20—Family Service Association of America. Biennial meeting. Detroit, Mich.

Nov. 20–23—American Academy of Pediatrics. Seventeenth annual meeting. Atlantic City, N. J.

Photographic credits:

Cover, Esther Bubley for Children's Bureau.

Page 51 (left), Arthur Rothstein for Farm Security Administration.

Page 51 (right), Philip Bonn for Office of Education.

Page 53, courtesy of Arkansas State Board of Health.

UNITED NATIONS DAY, 1948

BY THE PRESIDENT OF THE UNITED STATES OF AMERICA

A Proclamation

WHEREAS the people of the United States are united in a firm resolve to cooperate effectively with other countries, through the medium of the United Nations, to the end that a future of peace, freedom, and justice may prevail upon the earth; and

WHEREAS it is fitting that the devotion of the American people to the ideals expressed in the Charter of the United Nations should be reaffirmed in our inmost hearts and expressed in public ceremonies; and

WHEREAS it is our desire that our support of the United Nations be given added strength and positive affirmation through the activities of an informed public; and

WHEREAS the General Assembly of the United Nations, on October 31, 1947, unanimously adopted a resolution declaring that October 24, the anniversary of the coming into force of the Charter of the United Nations, "shall henceforth be officially called 'United Nations Day' and shall be devoted to making known to the peoples of the world the aims and achievements of the United Nations and to gaining their support for the work of the United Nations"; and

WHEREAS the General Assembly, in the same resolution, invited the member governments to cooperate with the United Nations in securing observance of United Nations Day:

Now, therefore, I, HARRY S. TRUMAN, President of the United States of America, do hereby urge the people of the United States to observe October 24, 1948, as United Nations Day by exercises exemplifying our recognition of the achievements of the United Nations, our support of its aims, and our determination to strive for the realization of those aims.

And I call upon the officers of the Federal, State, and local governments, as well as upon civic, educational, and religious organizations and institutions, and also upon the agencies of the press, radio, and other media of information, to cooperate in programs designed to give public expression to our devotion to the United Nations and to make more effective our participation in the work of the United Nations; and I urge our citizens to participate actively in these programs.

IN WITNESS WHEREOF, I have hereunto set my hand and caused the Seal of the United States of America to be affixed.

DONE at the City of Washington this ninth day of September in the year of our Lord nineteen hundred and forty-eight, and of the Independence of the United States of America the one hundred and seventy-third.

Harry Truman

By the President:

Secretary of State.

VOL. 13, No. 4 OCTOBER 1948

the CHILD

published monthly by the
Division of Reports
CHILDREN'S BUREAU
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Art Editor Philip Bonn

FEDERAL SECURITY AGENCY
Oscar R. Ewing, Administrator

SOCIAL SECURITY ADMINISTRATION
Arthur J. Altmeyer, Commissioner

CHILDREN'S BUREAU
Katharine F. Lenroot, Chief

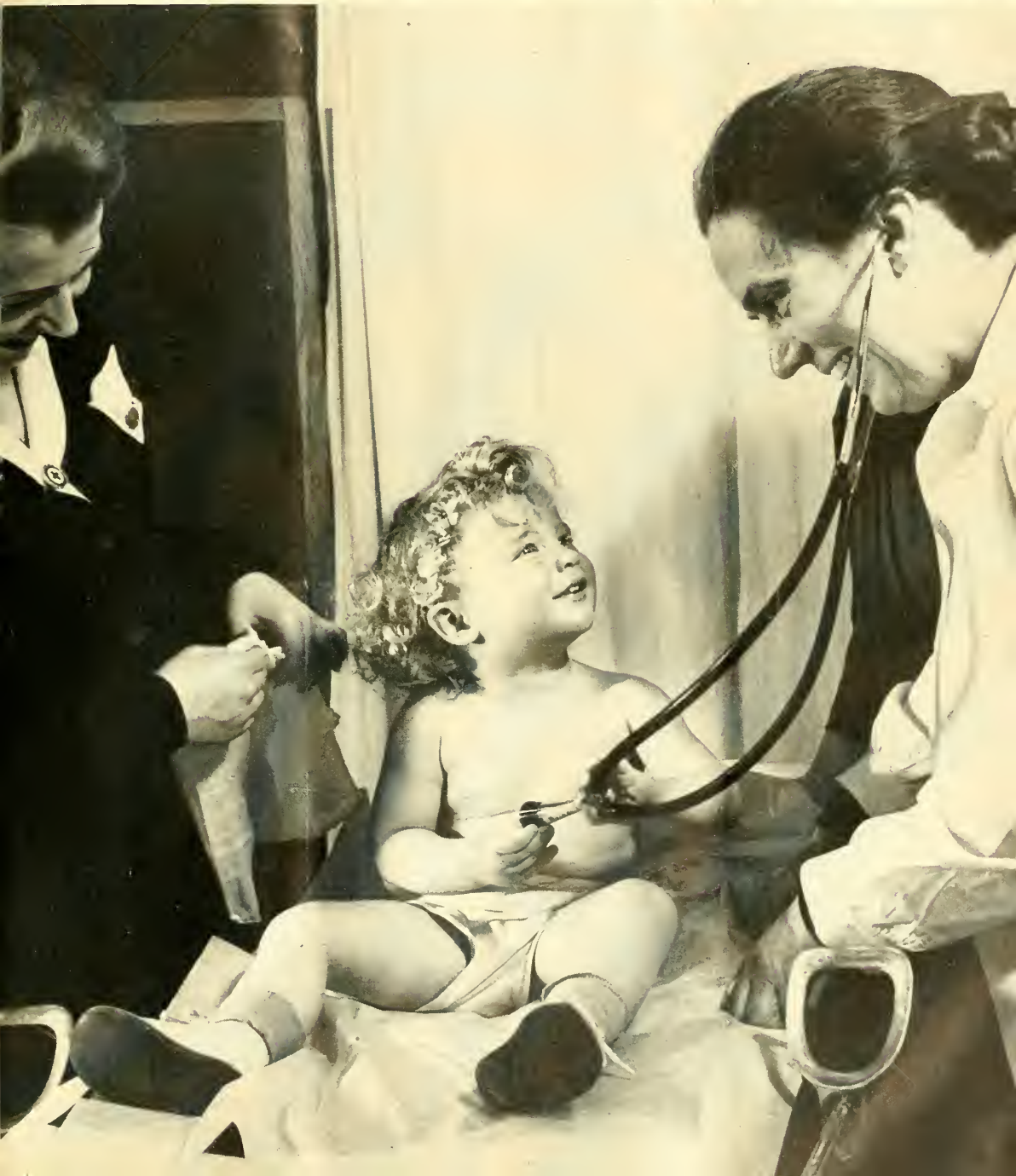
CONTENTS

Publication of THE CHILD, monthly bulletin, was authorized by the Bureau of the Budget, May 12, 1936, to meet the needs of agencies working with or for children. The Children's Bureau does not necessarily assume responsibility for the statements or opinions of contributors not connected with the Bureau. THE CHILD is sent free, on request, to public officials and libraries. For others, the subscription price is $1 a year. Single copies, 10 cents. Send remittance to the Superintendent of Documents, Government Printing Office, Washington 25, D. C.

U. S. GOVERNMENT PRINTING OFFICE: 1948

NOVEMBER • 1948

the CHILD



HEALTH IS EVERYBODY'S BUSINESS

Federal Security Administrator Proposes a 10-year Program for the Nation's Health

"OUR people want good health and are willing to work to achieve it." On this premise the President of the United States last January asked Federal Security Administrator Oscar R. Ewing to study how it is possible to raise the Nation's health levels, and he requested Mr. Ewing to report to him on goals for the next decade.

The Administrator's report to the President has now been published; it is called The Nation's Health—a Ten-year Program. It starts with our national health as it is today and points the way toward progress. And it urges that each community join with the State and Federal Governments in an action program for meeting the health needs of all. Mr. Ewing bases many of his recommendations on the findings of the National Health Assembly, a group of more than 800 professional and community leaders who met at Washington last May to advise with him.

As an indication of what can be done for the health of the Nation the Administrator lists some of the great achievements of the past. Twenty years of life, he reminds us, have been added to our average expectancy. Certain disastrous epidemics have been virtually eliminated as a threat to health in the United States. A generation of stronger, better-fed children has arisen; and we have more knowledge about the child—his physical, mental, and social development—from before birth to the age of 6 than we have about any other period of human life. We now have a vast storehouse of knowledge about preventing and curing diseases. And the death tolls from many diseases that were high on the mortality lists of the past have been sharply reduced.

Medical skill has done all that in the past. But medical skill is so far ahead of the availability of medical services, the report shows, that every year some 325,000 people die who could be saved if every one of us received the health and medical services that we need.

In the years from 1936 to 1945 the Nation has cut its infant mortality rate by one-third, and its maternal mortality rate by nearly two-thirds.

But today every 19 minutes an infant dies whose life could have been saved. Every 4 hours a mother dies in childbearing who might have been saved.

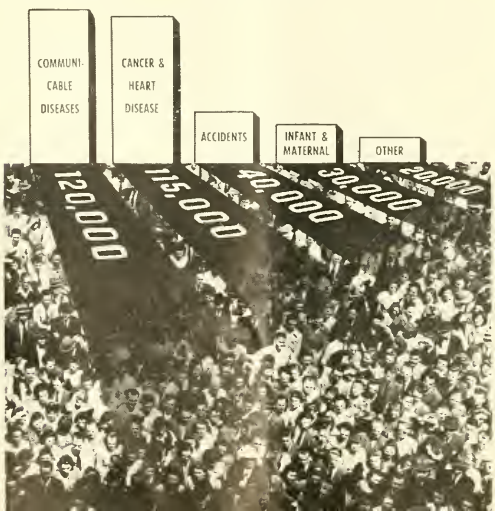
Health personnel and health facilities in this country, says Mr. Ewing, are in many respects totally inadequate when measured against the requirements of 143,000,000 people.

This situation is incompatible with our position as the world's leading democracy, and our total effort for health is completely out of pace with our expanding economy and with our national aims for the people's welfare.

The report lists the key health problems of the country under five heads: Manpower, hospitals, local organiza-

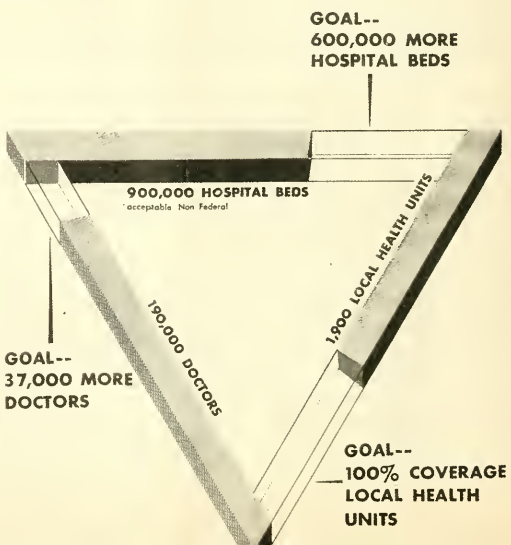
GOAL: KEEP THEM LIVING

We have the knowledge to prevent 325,000 deaths each year



GAPS IN OUR HEALTH SERVICES

Feasible goals for 1960



tion, research, and individual cost of care.

Manpower

Our health manpower—physicians, dentists, nurses, and supporting personnel—is insufficient in numbers and so poorly distributed that large sections of the country and many millions of people are without even minimum health and medical services. We have only 80 percent as many physicians as we need and even greater shortages of other medical personnel.

Moreover, we do not have enough medical colleges, training schools, and teaching hospitals to close the gaps between need and supply at any time in the foreseeable future. The financial condition of most training institutions is such that they have great difficulty in maintaining standards of quality and, without help, can rarely even consider increasing their production of needed manpower.

Hospitals

Our hospitals and other health facilities have not kept pace with our needs. We have only about 50 percent as many acceptable hospital beds as we require. Only through the recently enacted Federal Hospital Survey and Construction Act has there been any Nation-wide effort to plan construction on a State or a regional basis. For the most part, hospitals have been planned, constructed, and operated without reference to the economic and efficient provision of the wide variety of services expected in modern institutions. They operate mostly as independent units, without reference to one another, without arrangements to provide their patients, through integration with other institutions, the services which they individually lack.

Local organization

The Nation's health resources are not used at full efficiency. Public and private services alike have for the most part grown up without effective plan. Some 18,000 local political units provide some form of health and medical services. About 20,000 voluntary health organizations and some 6,000 hospitals are operating in different communities, each segment generally independent of the rest. The lack of organization in many communities throughout the country makes it impossible for them, and for many of their citizens, to obtain even those services that are available in their regions. There are grave shortages in such fundamental provisions as local public health departments; where they exist, they are largely understaffed and underfinanced.

Research

Our search for new knowledge about man and his human need is feeble compared with our search for knowledge that will contribute to material wealth. Nationally, we spend more than $1,000,000,000 on all types of research, of which industrial and military investigations constitute the bulk. Only a little more than 10 percent of this total is devoted to medical and related sciences.

Individual cost of care

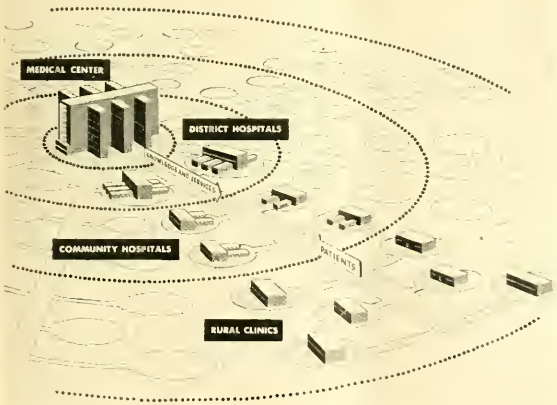
Perhaps the basic lack of our entire health effort is the absence of any method that would permit the individual, regardless of the level of his personal income, to obtain the kind of services he needs to achieve better health.

A scant 20 percent of our people are able to afford all the medical care they need.

About half our families—those with incomes of $3,000 or less—find it hard, if not impossible, to pay for even routine care that every family needs.

Another 30 percent of American fam-

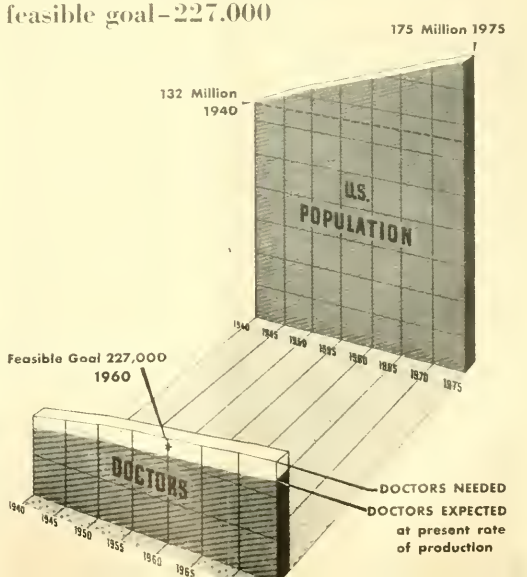
BETTER HOSPITAL INTEGRATION MEANS BETTER HEALTH



A CO-ORDINATED HOSPITAL SYSTEM, though a free-flowing exchange of medical services and patients, would offer the highest quality medical care to all communities, even the most remote. The *medical center* would combine training, extensive research, expert diagnosis and treatment of complicated cases. Several *district hospitals* would provide general and special services for most hospitalized patients; as, major surgery, pediatrics, obstetrics, psychiatry. *Community hospitals* would offer more limited services, referring more complicated cases upward. *Rural clinics* would serve chiefly as out-[illegible]

WE NEED MORE DOCTORS

By 1960 we need 254,000: feasible goal–227,000



ilies with incomes between $3,000 and $5,000 would have to make great sacrifices or go into debt to meet the costs of a severe or chronic illness.

For the community, this lack of purchasing power helps to limit the number of doctors and other personnel who will practice there. Equally, it places high barriers in the path of building up adequate health facilities.

Confronted with our inadequacies in health facilities and resources, and with what they cost in needless deaths and suffering, the report says, the Nation has clear alternatives:

One is to continue with the present general pattern, with chief reliance on slowly increasing economic levels and consequent increased demand to spur expansion of services.

To apply discoveries takes time

The other is to strike out boldly, but with careful planning, to bring our health resources quickly into line with our national and individual needs.

If we continue in the present pattern, the Administrator says, it is true that there will be gradual improvement in some parts of the country, but in general the gains will come in those areas which already have a relatively high level of health services. The present impoverished and underprivileged districts will lag far behind. New gains may be expected through the progress of science, but the application of these discoveries will be slow. The development of the Nation's health services will be left at the mercy of economic cycles as it has been in the past.

Mr. Ewing proposes that Federal subsidies be used to step up the supply of health personnel and facilities. He points out that medical schools are today crippled by lack of finances; yet to achieve the supply of physicians actually needed by 1960 would require doubling immediately the training capacity of medical schools. Public funds, says the report, are the only source of income sufficient to expand the schools to the degree necessary to meet such requirements. At the outset, it is estimated, medical schools would probably require $40,000,000 a year from the Federal Government in addition to all foreseeable contributions received from State and private sources.

A second major proposal is for a Federal system of health insurance. Mr. Ewing reports: All our analysis of the problems of health have brought us again and again up against a single stone wall barrier—the inability of millions of the people to meet the costs of health service.

Millions fail to get adequate medical care

The report points out that not only does this impair the health of millions of people, but it also acts to restrict the construction of hospitals, the expansion of medical schools, and the development of needed medical services.

Voluntary insurance plans cannot do the job that has to be done, the report states, and continues: Under these circumstances, we have only two alternatives: We can plan a method of prepaid Government health insurance that can be tailored to meet the Nation's needs, or we can go ahead as we have in the past.

Mr. Ewing explains that there are many earnest people in the country who sincerely urge the latter course. They point out that American health is equal to the best in the world; they feel that it is dangerous to make any basic change in the system that has produced this achievement. He adds, I cannot accept this thesis. We can improve the Nation's health markedly. What was good enough 30 or 40 years ago no longer is adequate. He further points out that the present system of paying for medical services is the system under which millions of our people are unable to obtain adequate medical care or services.

We are slow in building hospitals

The Administrator applies the philosophy of "continuing as we are" to the need for hospital construction: At the rate we are now building hospitals, he says, we will meet 1946's needs in 1986—40 years too late.

A gradual expansion of health resources sufficient to meet the Nation's need by 1960 will naturally require an increase in spending by local, State, and Federal governments. The report estimates that by 1960 the States and local governments should be spending an estimated $1,795,000,000 and the Federal Government an estimated $2,312,000,000. This would represent approximately twice the present outlay of Federal funds.

All the help the Nation can give, however, says Mr. Ewing, will prove insufficient unless the communities themselves enter wholeheartedly into the work.

The first step, as the National Health Assembly's Section on State and Community Planning recommended, is for people interested in local health problems to get together—as they did in the National Assembly. There, technical experts and representatives of professional and consumer groups met in good will to ask questions about health and medical problems, and to agree on many solutions. Similar local or regional congresses, asking similar questions of importance to their own communities, can make a sound beginning on cooperative study and action.

Questions needed

Mr. Ewing says that local assemblies will find the need to ask, and to answer, such questions as:

1. What is the state of health, and what are the health and medical services in our community as contrasted with achievements elsewhere, and as contrasted with the national goals?

2. What health goals can we attain in the next 10 years on the basis of existing health conditions and medical knowledge?

3. How can we organize our health and medical resources so that every person in our region has access, in health and sickness, to the highest quality of services?

4. What should our State and Federal governments do to assist us? Our professional societies? Business, industry, and philanthropic institutions?

5. How can we make sure of an adequate annual expenditure of funds to supply those needs?

We need to ask these questions and many more, says the Administrator. All of us need to ask. Civic, professional, and Government leaders will want to meet and look into health problems, but so will consumer and social groups, labor and farm organizations, business, and management representatives, he continues. Health is everybody's business. Everybody should want and demand for himself, and for

those dependent upon him, the best of health and medical services. He must ask why he is not receiving them and what can be done about it.

What are the answers?

The asking of the questions is, of itself, an important effort, Mr. Ewing goes on to say. All growth starts with that kind of inquiry. Progress comes through the effort to make constructive answers. As a people then, we must get together in every urban and rural community, in every State and region, and organize that unified and democratic teamwork which alone can answer our questions fully in plans and action for health.

In a chapter entitled "A Good Start in Life," the Administrator reminds the Nation that the foundation of positive health must be built in childhood. Everything we do to assure children a healthy start in life improves the chances of health in maturity.

Achieving physical, mental, and social well-being is a growing process that starts even before birth and continues, step by step, as a child gradually matures into an adult, the report goes on.

The very process of growing up, says Mr. Ewing, creates special physical, mental, and social health problems which are quite distinct from the problems involved in protecting, maintaining, and increasing the health of adults. Children are not pocket editions of adults. The health care they need is both qualitatively and quantitatively different.

Childhood is the period when every expenditure of effort in cultivating good health can yield the greatest dividends, the report says. It is also the period when neglect of health can be most costly.

In the last 20 years, the Nation has made great progress in child health, but the work is still far from complete, the Administrator continues.

Look to the future

Concerning the future of children's health, the Administrator says that it is in the national interest that all children everywhere—regardless of race, color, religion, or economic status—should receive the same quality of good health service and medical care. Advances made in one area should be made available to all.

The speed with which we place medical care and health services within reach of every mother and child, he continues, will depend importantly on the speed with which we accomplish our total health goals. Beyond this, it will depend on public funds for financing special services for mothers and children.

Establishing adequate programs of child health will require two parallel types of financing, says the report.

To finance child-health programs

A part of the problem of financing child and maternal care is the lack of any system of Nation-wide insurance to make health and medical services available to everyone, continues Mr. Ewing. Half of our children live in families that, in 1945, had incomes of less than $50 a week; almost half live on farms or in rural communities where, largely because income levels are low, health services and medical care are most inadequate.

Financing medical care will be best accomplished for children, says the Administrator, by a national system of prepayment for health services, supplemented by public health services.

Most rural counties lack health service

Every State has made at least a beginning toward supplying the needed community services by setting up in its health department a special division devoted specifically to maternal and child health, the report goes on. No State has yet been able to supply all types of services required, or to reach all the children in need of care. Three out of four rural counties, for example, have no regular monthly well-child clinics—a minimal service.

Along with the expansion of funds for services to children we will need an increase in research, the Administrator says.

Premature birth is a major cause of death in infancy, and care to save the prematurely born infant is expensive. Compared with these costs, the expenditure for research is insignificant. There is urgent need for further basic knowledge as to cause of abortion, premature labor, toxemia, sterility, and fertility.

Research is needed into the causes of congenital malformations, of cerebral palsy, and other types of crippling conditions, the report continues. A companion study of the kind of community and family where these conditions occur should throw light on the kind of programs to meet these problems.

Mr. Ewing goes on to say that the Nation spends millions on children who are delinquent—an emotional illness in itself—and neglects research into the psychological and social factors behind juvenile delinquency. The interaction of a child and his environment is so complex that research in this field must call on the students of medicine, psychology, psychiatry, anthropology, sociology, social work, education, economics, and other sciences.

Types of needed research include the study of family as an institution, the Administrator's report goes on to say. The family is undergoing rapid changes and we need to know their implications in the growth and development of children.

Personality and environmental factors behind various kinds of child behavior also require study, according to the report. The history of behavior patterns of normal as well as of problem children, of impaired and handicapped children, would help explain the source of their problems and to improve parent-child relations. Early infancy is full of psychological problems for which our answers so far are largely in the form of theory and speculation.

Mr. Ewing ends his report with a plea for community action.

"A popular movement for health, working together for health, is in the last analysis the only way in which we can raise the standards of health in our own communities and for the Nation. If the people will get together in citizen health councils throughout the country, we will have the satisfaction of proving not only that health is everybody's business but that it is good business, essential business, and successful business."

For the basic health goals for the 10-year program, see page 80.

Copies of the report excerpted here are for sale by the Superintendent of Documents, Government Printing Office, Washington 25, D. C., at $1 a copy.

"HOME HELPS" FOR AUSTRALIAN FAMILIES

IN EACH OF Australia's six States, some household help can be had by mothers of young children when the mother is sick, or having a baby, or when some other emergency makes it impossible for her to manage her household.

The workers, given different titles by the agencies that provide them, but usually called "home helps," as they are in Great Britain, do the mother's duties of taking care of the children, marketing, cooking, washing, and so forth.

In all the States the organization responsible for the service pays the salary of the home help and charges the family for the service. If the family cannot pay the full cost, the organization charges what the family can pay without hardship. The salary rate is comparable to the rate of pay for women in industry and in office work.

The practice of the organizations that provide the service varies considerably in the different States. Following is an account of the work as it is done in each of the six States that make up the Australian Commonwealth: New South Wales; Victoria; South Australia; Queensland; Western Australia; and Tasmania.

New South Wales

In Sydney, the capital of New South Wales and Australia's largest city, the Housekeepers' Emergency Service, a voluntary social agency subsidized by the State, provides about 40 experienced housekeepers. A housekeeper may reside in the home or may go there daily. She is assigned to a family for not more than 3 weeks except in urgent cases.

A staff member visits the home to judge the need for a housekeeper when an application for service is received directly from a family, but not when the application comes from a recognized social-welfare agency.

The Housekeepers' Emergency Service is extending its service to Sydney's suburban and outer areas in cooperation with the State Department of Labour and Industry and Social Welfare. The Department has a large number of local offices in which branches of the housekeeping service are to be established. Because of this extension of service, Sydney municipal councils are not setting up home-help schemes as are those in Melbourne.

Victoria

In Melbourne, the capital of Victoria and the Commonwealth's second largest city, a number of municipal councils and several voluntary agencies provide home-help schemes.

In some areas of Melbourne these schemes are managed by the municipality itself; in other areas by local voluntary organizations sponsored and helped financially by the municipality. The schemes generally cater to expectant and nursing mothers.

The housekeeper is entitled to 2 hours off duty each day, and to a day, or a day and a half, off each week.

One scheme conducted by a local private organization in conjunction with the municipal authority maintains a hostel where its housekeepers may spend their time when off duty and where they may live between jobs.

Two voluntary organizations—the Young Women's Christian Association and the Country Women's Association—conduct home-help schemes in Victoria.

The YWCA employs only one housekeeper. Her time with a family may not exceed 4 weeks; usually it is 2 or 3 weeks. The YWCA housekeeper always lives in the home of the family she is serving. The association requires that she be given a room to herself and that she have 1 full day off duty each week, or 2 half days.

The Country Women's Association in Victoria provides a home-help scheme, employing eight housekeepers, who are available to members only. The Victorian Railways provide free transport for these housekeepers.

The Geelong group of the association (Geelong is a provincial city 45 miles west of Melbourne) has appointed a housekeeper to work under similar conditions and for a similar purpose.

South Australia

In South Australia the Children's Welfare and Public Relief Department conducts an Emergency Housekeeper Service. The department supplies housekeepers to mothers of young children under the usual circumstances and also when the mothers are ordered to take a rest or a holiday by their doctors.

While the mother of these Australian children is in the hospital for an operation, a "home help" does the household tasks, takes care of the children, and tries to keep them happy.

This article, on Australia's "home helps," is based on information supplied by the Director General, Australian Commonwealth Department of Social Services. It is one of a series that *The Child* is publishing on what we in the United States call homemaker service. The principles of such service were discussed in the August 1947 issue of *The Child, and* the next article in the series sketched the development of homemaker service in Finland; this was published in July 1948. We expect to publish others from time to time.

The period of employment for which housekeepers are available is generally from 2 to 4 weeks, and the maximum period is 6 weeks.

The department employs housekeepers to staff the service on both a permanent and a temporary basis. Permanent housekeepers are paid at a different rate when they are on duty and when on call. Temporary housekeepers, who receive a specified amount a day while working, may earn permanent status by serving a probation of two placements.

The department stipulates conditions of employment for workers living in—that the housekeeper have 1 day off duty from 10 a. m. to 11 p. m. and that she have a sleeping room to herself. Permanent housekeepers of the service are entitled to 2 weeks of annual leave each year after 12 months of service and to 16 days of sick leave a year. Annual leave is paid for at the rate of working time and sick leave at off-duty rates.

Queensland

In Queensland three voluntary organizations are responsible for providing home-help services, the Red Cross (Aid to Mothers Section), the Mothercraft Association, and the Country Women's Association.

The Aid to Mothers Section of the Red Cross provides 14 emergency housekeepers called "daily helps." A trained sister (as nurses are called in Australia) who is attached to the section visits homes to investigate applications for service. She also supervises the work of the housekeepers in homes.

The Mothercraft Association conducts a Mothercraft Service Bureau with an average of five trained home assistants in Brisbane, Queensland's capital and largest city. In Toowoomba, 100 miles west of Brisbane, it conducts a bureau with an average of four trained workers.

The association has a training course for persons desiring to become home assistants. This course trains about 16 assistants each year. Certificates are presented to women who have completed the course and also a 12-month probationary period at work.

Many centers of the Country Women's Association throughout Queensland have organized emergency housekeeper services. The association employs about five housekeepers in all. They are available to all mothers in the areas served, not only to members. Free railway travel is accorded housekeepers by the Queensland Department of Health and Home Affairs. Centers having housekeeper service include Brisbane, Ipswich, Toowoomba, Maryborough, Rockhampton, and Cairns.

Western Australia

The Lady Mitchell Emergency Housekeeper Service is the main service operating in Western Australia, the most sparsely settled of the States. This is conducted as a voluntary social service. It provides housekeepers to families living in the country districts. Applicants for service face no long waiting periods because the service employs quite a number of housekeepers and places them for short periods only.

A few branches of the Country Women's Association in Western Australia conduct housekeeper services on much the same lines as other State divisions of this association.

Tasmania

The only State to translate the Australia-wide interest in home-help schemes into legislation is Tasmania, the island State. In 1947 the Tasmanian Parliament passed an act that is unique in Australian social service. It gives the State government power to ensure home help to all families needing it. The State may establish a domestic-assistance service of its own, it may subsidize services provided by approved associations, and it may establish hotels for women who are employed, or being trained, as domestic assistants.

Regulations were issued under this act early in 1948, indicating the procedure to be followed by organizations wishing to be approved, the rate of subsidy by the Governments, and the terms and conditions of employment of workers. Each employee must receive 6 days' leave out of each 28 days' work. The State is to grant to approved associations a specified amount a week for each domestic assistant they employ.

The Country Women's Association, which has conducted a home-help scheme for some time, is the first association to be approved under this new act and to receive a State grant.

The Red Cross Society in Tasmania has a home-help scheme that assists medically discharged servicemen and their families. The Society assists such men when, because of the illness of wife or mother, they face caring for the family besides doing their own work.

If this Australian family had been unable to get help, the children would have had to be separated from their father while the mother was away. As it is, the family remains together.

Home help a social service

Australians realize how important it is that household help be provided to families during emergency periods when it would otherwise be difficult, or even impossible, to keep the children together in their own home. Therefore the establishment, by various agencies, in all six States of Australia, of schemes for providing such home help is recognized as an important advance in one aspect of social services.

Reprints available in about 3 weeks

WHEN A COMMUNITY PLANS FOR MENTAL HEALTH

GEORGE S. STEVENSON, M. D.

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IN ALL PLANNING for community functioning the resident of that community should be the constant point of reference. What happens to him will determine the validity of the plan, even though at present it is the pattern, the tradition, and professional prerogative by which we tend to measure community function.

My first proposition is that community function is a dynamic process, to be planned specifically for each community.

Today doctors, lawyers, clergymen, social workers, teachers, and many others with formal professional training participate in community planning. But the only profession that has adopted the study of community function as a regular part of its professional training is social work. And such training is often of a static sort.

Each agency affects the community

There is a current fallacy that community planning can be vested in one agency, perhaps the council of social agencies, and usually the planning actually occurs through such an agency. However, most such planning is done under the influence of local, State, and national agencies in the various fields—specialists in health, welfare, education, and so forth. Unless these agencies and the community realize that community-wide influence is exercised each time any one of them introduces a change of plan, confusion is apt to result and often it does.

Every such agency is an agency of community organization, and unless it is equipped to carry this responsibility it is apt to render a disservice.

And so I present as proposition number two: Community planning is a function of all health, welfare, education, and like agencies and should be prepared for in the professional training in each of these related fields.

Let us consider the genesis of community services. For the most part they began as response to a need, or to a nuisance that had become unbearable. The steps in the response were direct, simple, and palliative. Lack of food and shelter was met by giving food and shelter. Inability to read, write, or figure was removed by teaching. The person concerned was given little thought. But as inquiring and conscientious persons came to be responsible for fulfilling the needs or abating the nuisances, they more and more sought to find the underlying causes of the trouble and to work toward prevention of them.

In pursuing this line, the different fields found themselves working in the same territory. The first reaction was one of conflict, for each naturally believed that this new territory was part of his field and was therefore his own. This conflict has complicated many efforts at community planning, but it is not an unmixed evil. It does represent a coming together of fields that were previously completely isolated, and out of the conflict, again and again, have come understanding and collaboration.

I offer then a third proposition: That interagency conflict is a part of the normal growth process of community agencies and is potentially the precursor of interagency collaboration.

This proposition really says that each agency in the community is only partly responsible for the work, even in its own field.

It makes the point that a community's mental-hygiene planning, for example, cannot be restricted to agencies that are specifically labeled as mental-hygiene agencies, but that the quality of the mental-hygiene work is dependent upon the quality of work done by the schools, the courts, the children's agencies, the health agencies, and others in the community. Each agency has a stake in the quality of work done by every other agency.

Progress in any field depends upon general advancement in the agencies of the community, and if one agency is retarding this progress it is a responsibility of the others to do something about it, and not to stand off in respectful silence.

This third proposition also has some implications for a proposal to set up a general intake agency in the community, through which all beneficiaries would pass. People go to the agency that has helped them before. They do not analyze their problems sufficiently to make application to exactly the right agency. But if an attempt is made to sort them out into several specialties from the very beginning their confidence in a particular agency is lost. They feel shoved around and confused because the burden is put upon them to coordinate the services, when the professional fields themselves cannot effect this coordination.

The answer is to develop within each agency a generic function, providing help for some distance beyond that which can be provided by a friend, a neighbor, or other lay person. It is when this generic competence is exceeded that the need for the specialized function of each agency comes into being.

The generic responsibility of each agency requires certain specific things by way of professional preparation. It requires a knowledge of the family and how it works. It requires a knowledge of how to talk with people effectively, an understanding of anxiety, and skill in helping the patient over the bridge to a special agency when this is needed.

Out of this we might derive a fourth proposition: That each agency in the community must be prepared to provide a generic service in helping people with the simpler aspects of problems and must refer them to other agencies when specialized service is needed.

This proposition, of course, raises the question, How shall the division of labor in these closely interrelated functions of the community be worked out? Some communities have tried to create omnibus agencies designed to cover all needs, but unfortunately the attempt at comprehensiveness further obscures the

Given at the National Health Assembly, held at Washington, D. C., May 1–4, 1948.

need for working with other agencies.

The only answer seems to lie in a division of labor between agencies, based upon technical differences; centralizing the administrative work, but at the same time making provision for decentralization of the people to be served in order to provide the least confusing service.

Within the framework of these general principles of community organization we must clarify the functions that the community must perform for its people and, in general, the auspices under which these functions are to be administered.

A public-health nurse is in a strategic position to help people, for she has a chance during the first 5 years of a person's life to influence the family setting in which he grows up.

Dr. James S. Plant has given us an excellent guide as to how to identify these functions, namely, through paying attention to the leads that are given to us by almost every case of breakdown. Patients tell us by implication where in the community more planning is needed, and their own life stories give us the argument in favor of this planning.

If we study the needs of these patients in relation to the functions of the community, we find that there are six general areas of community function applying to mental health.

Starting from the gross end, the first such area—and to date almost the only fully recognized need—is for hospitalization of persons who can no longer get along within the community. Unfortunately the fact that such hospitalization is under the auspices of the State has made us lose sight of the fact that the community still has a function in serving these patients.

As a result our mental hospitals have become isolated and the community has not maintained sufficient interest in the patient to ease his return to home, to neighborhood, to normal social functioning, and to a job. Most of the ills of our mental hospitals go back to this severance from the community.

The community likewise has failed to provide for adequate care of the patient while he is awaiting a decision on hospitalization and also while he is waiting to enter the hospital. Development of psychiatric facilities within general hospitals would correct a large part of this defect.

The second area of community function in the realm of mental health has to do with patients who have returned from hospitals. Most communities, and most hospitals, do little about this. The convalescent patient is left to shift for himself. Aid to such persons calls for the combined efforts of the hospital social service, the local clinic, rehabilitation and employment agencies, and agencies for the health, welfare, and educational needs of the family.

The third area of this type of function deals with persons with psychiatric problems who do not require hospitalization. The public psychiatric clinic and to a lesser extent the private physician are the usual resources for meeting this need. We are at present facing somewhat the same risk with clinic service that we do with the service of mental hospitals, since in some States there is a tendency for the State to assume full responsibility for clinics.

The need is clear for effecting a continuum of function between the clinic and the hospital, but there is no fundamental need to put clinics under the hospital.

Stress local responsibility

Every effort should be made to keep the responsibility for clinics as close to home base as possible, in close touch with other community agencies and with the racial, cultural, religious, and occupational characteristics of the community. The function of the State should rather be to encourage local responsibility in the more advanced communities and to withdraw successively from these as they mature, with the prospect of keeping under State auspices more or less permanently only those communities which are too weakly organized to care for themselves.

Within the community the psychiatric clinic cannot be conceived of as carrying the full load of caring for persons with emotional disorders. That is neither economically possible nor clinically desirable. The complementary function will be discussed under area number four, to which I shall come later.

The details of the organization and operation of psychiatric clinics have been fully discussed in the past, and so I shall not deal with intraclinic functions, with two exceptions.

Psychiatric clinics differ from other agencies in that their concept is based on a team of workers. The clinic team, as a rule, represents three professions, psychiatry, psychology, and social work. And this idea of team functioning is

applicable as an instrument for tying together all the services in the mental-hygiene field. Over the years many clinics have had other agency staff working with each patient, as if they were members of the clinic team. We should not lose sight of the unifying value of this plan, and we need to experiment with extending it.

The other phase of clinic work to which I specifically refer is the concept of the case. Today in nearly all clinics the case is thought of only as an opportunity for service to an individual; this must be the foundation of the work, but there are values beyond this.

Every agency that takes part in aiding people with their problems of mental hygiene has the responsibility of understanding many things, especially about the family and how it works.

Each case brings the clinic into touch with persons, especially professional workers, who lack the facilities or technical equipment to sense a problem in its incipiency and to do what they might about solving it. Such a person's interest in a case brings to him an unparalleled opportunity for education to strengthen his own professional competence.

Each case also shows wherein the community has been deficient in its resources in working for mental health. The case then becomes a potent argument to the community to improve its resources for recreation, individualized education, more comprehensive public-health facilities, and the like.

The first three areas—service to the hospitalized patient, to the convalescent, and to the out-patient, are a defense of the mental health of the community.

In terms of number of cases, however, by far the major job of the community in the mental-hygiene field is in a fourth area, in which health, welfare, educational, judicial, church, and other agencies deal with people in need or in difficulty.

To help these people the public-health nurse is in the most strategic position, because of her opportunity during the first 5 years of a person's life to influence the family setting in which he grows up. The clergyman has probably a comparable opportunity, but today he is further away from taking advantage of it. The schools and organized recreation are perhaps better prepared in general to exercise this function, but they appear on the scene only after much water has gone over the dam.

The need in all these agencies in the fourth area is specifically for a strengthening of professional equipment along the lines which I have referred to as generic function.

Then there is a fifth area in community mental-hygiene planning, which includes the strengthening of the community in order to make of it a better place for people to grow up and live in. This bears upon almost every phase of community function, as our patients will figuratively testify. It is concerned with providing more adequate recreational facilities, individualizing education, selecting mentally healthy teachers, and deriving satisfactions from productive labor.

In these five areas of community function for mental health, some of the services will be provided from public funds. Some will be under private voluntary auspices; and some, as in industry, will come out of proprietary effort. But the moving force behind these developments will be the mental-hygiene society, representing the citizenry as a whole. Citizen mental-hygiene organization today is weak because it operates at national and State levels and not at the local level, where it is closest to the people who are its greatest asset.

This leads us to the sixth area in the community plan, which is the education of the public generally. This is a combined responsibility of all agencies, public and private, that have a part in the mental-hygiene field. But again it is spearheaded by the voluntary mental-hygiene society.

It is obvious that these general principles of community organization and these six areas of mental-hygiene community function are far beyond our present realities, although enough has been achieved here and there to enable us to chart these principles and areas with some confidence. The advances made under the Federal Government in the past 5 years with the Medical Survey Program of Selective Service, the Federal Vocational Rehabilitation Act, the Hospital Construction Act, the Veterans' Administration program, the National Mental Health Act, and developments within the Children's Bureau give me confidence that we have reached a point where effective effort over the next 10 years will make real many of these things which I have referred to here, which up to now have been accomplished only in token form.

Reprints available in about 3 weeks

CALIFORNIA COMMITTEE STUDIES TRANSIENT YOUNG PEOPLE

MARY B. PERRY

Superintendent, Ventura School for Girls, and Director of the Study of Transient Youth

TRANSIENTS and migrants are one of California's most talked-of problems. They have always been a problem in the State, and consciousness of their presence was accentuated during the depression years, when Federal funds were used for the first time to give services to transients, and again in the war years, when new groups of people were encouraged to come to California to work in war industries.

California's laws allow public financial assistance only to persons with at least a year's residence. This further intensifies the problem concerning transients, for, with one exception, the State department of public health, there are no authorized public or private agencies to help newcomers.

The California Youth Authority, which was established in 1942 by the State legislature to handle problems connected with delinquency, was quick to become aware of the large numbers of young people who were sent to it for return to their State or legal residence, although many had no actual delinquency record in California.

Committee continues wartime efforts

The Youth Authority brought its concern for these young people to the attention of the California Youth Committee, a citizens' committee that was appointed in 1942 by the Governor to study the problems of youth in the war years and has continued to function in behalf of young people and their problems.

The California Youth Committee in 1946 asked its subcommittee, called the Committee on Transient Youth, to make a study of the young people who come into the State without parents or guardians. This committee obtained funds from the Rosenberg Foundation in the spring of 1947 to study the problem.

Because it is obviously impossible to get an accurate count of the number of such wandering young people at any one time in a State 900 miles long, with a total population over 10,000,000 and a concentration of population in large urban centers, the study staff, which comprised only the director and an assistant, had to use methods other than personal contact with transients.

The committee was interested not only in statistics: it was interested in knowing the character of these boys and girls who were considered such a problem by the State. It decided, therefore, to make a sampling of the problem.

Fifteen cities were chosen—including most of the State's largest cities—scattered up and down the State, some in farm areas and some near the border, where people coming into the State might normally enter.

In these 15 cities every social agency that might, under any of its functions, give assistance to transient young people was asked to collect certain information from these young people on 2 specified days. An agency representative interviewed each person under 22 that the agency was in contact with on either of the 2 days set for this sampling, if he had not been living in the community more than a year and was not living with his parents. The agency also had each of these young people fill out a questionnaire that had been formulated by the survey committee.

Public and private agencies—National, State, and local—churches, and law-enforcement workers accepted the responsibility for obtaining the information needed, and the success of the study is largely due to them.

Through these contacts, 1,079 young people filled out schedules. Of these, 145 were being held by the California Youth Authority for return to their own States, and the schedules on these 145 were not all filled out on either of the 2 days of the survey, as the young people were then in custody.

The committee also asked the California Department of Agriculture, which maintains border stations at 18 main roads into the State for the purposes of pest control, to check incoming cars during the period of the week end previous to and including each of the two Mondays on which the survey was made.

At the border stations no attempts were made to secure schedules. A count was made of young people coming in who were not with their parents by asking the simple questions, on busses or in cars: "How many of you are under 22?"; "Traveling alone?"; "Why are you coming to California?" In this way 1,335 unattached young people under 22 were counted coming into the State on the two week ends.

A check of the railroads was also made. Very few young people appear to be traveling on passenger trains at this time, and the railroads are keeping careful records and turning over to the police unattached young people under 18 years of age found on freight trains.

Many youngsters in custody

Significant facts were brought out by correlating the data from the 1,079 schedules used as the basis for the survey report. Nearly 30 percent of these young people were under 18 and one-fifth of them were girls. A smaller proportion of the girls than of the boys were over 18, and two girls 11 years old were found. Among the young people under 18, most of them were interviewed when they were in the hands of the authorities, police, probation officers, or the Youth Authority. This rather startling fact is a direct result of a lack of agency jurisdiction, and of the curfew laws in California, which mean that unattached young people are apprehended by the police after curfew hours.

Most of the young people interviewed were coming to California looking for work. The California Employment Service offices and farm labor offices accounted for over one-fourth of the

total number of applications turned in. Most of the young people who contacted social agencies stated they were in California looking for work because they thought the opportunities for advancement were better in California and because many of them had been in military service in this State and were drifting back because they liked it here. (Special interest to the State in this study was the problem of the young veteran, and it was in order to sample this group that the upper age limit for the study was set as high as 22.)

The stories that were told to survey workers would make material for feature stories and for social case-work records in every State. There were girls who had run away from home because of family and marital difficulties, and boys who had been forced to leave home because of overcrowded living conditions and the fact they should be on their own because of family need. Actually, these young people were above average in educational background and in their desire for further education. Many of them had come to California with some money but at the time of their contact with the agencies were in need of assistance. The data showed the committee that they were not bums, but were the kind of pioneering young people who were responsible for building the West, and that they should be encouraged and assisted in making adjustments in California rather than being sent back to their legal homes without an analysis of their problems.

In addition to the material collected from the young people themselves, the committee circularized all the agencies who had participated in the study, asking for their estimate of the problem and of the ability of the agency to handle it now; as well as their recommendations as to how it should be met.

The material collected from these agencies is in some ways more thrilling than that collected from the young people because it accentuates time and time again the recognition of the problem, and the sense of frustration because there are no community organizations set up to handle the problems of guidance, counseling, financial assistance, recreation, and absorption into the community for this group of young people.

As would be expected, there are a number of agencies who felt these young people should be returned to their own communities and that their lives were not California's problem, but these were in the minority. It was clear that the people actually handling the problems of these young people realized their need for the services available to other young people in the community, but were handicapped because of lack of funds and lack of jurisdiction.

After the data had been collected and summarized, the California Committee for the Study of Transient Youth recommended to the California Youth Committee that "State and Federal legislation should be enacted, and administrative action taken, to give the same protection to transient, nonresident youth as is available to resident youth in the various States; to establish minimum standards of treatment, housing, education, and employment, equally for all, regardless of length of residence. To this end Federal and State laws should be enacted, and administrative practices revised, in the following fields."

The committee made three general recommendations, as follows:

What the committee recommends

1. Age alone should not be the determining factor in returning transients to their homes.

Many of the children under 18 who were interviewed by the study indicated that they came from bad family situations to which it would seem inadvisable to return them. Many of the agencies reported that parents were often unwilling or unable to assist their children to return, or to care for them at home. State and local agencies in California also indicate great difficulty in securing cooperation from community agencies in the home State of the young transient to assist in returning him there and supervising him after he has returned.

2. Migrant and transient youth should not be handled by the law-enforcement branches of government, except in cases of delinquent boys and girls.

All children picked up by the police should be referred immediately to social case-work agencies. When the transient is involved in a law violation, he should be treated as other juvenile offenders are.

3. Any planning for transient youth should give consideration to members of minority groups. Even in towns where housing and other care was available to other transient youth, it was almost impossible for these young people to get any help outside of jails.

The committee made specific recommendations, as follows:

Local—county or city

1. In every community there should be an organization of citizens and agency representatives to examine and coordinate existing services for transient youth and to plan and promote the establishment of such new facilities as may be necessary. The California Youth Committee should assume the responsibility for encouraging the formation of these local organizations, and when they are established be prepared to offer advice and counsel.

2. Services which should be made available for transient youth in the communities should include:

a. A method of financing an adequate program.

b. Housing facilities for temporary shelter and food, with trained supervisors in charge.

c. Counseling service, which should include help in the immediate problems presented by the individual, as well as information about and referral to other community facilities and agencies.

d. Available information on educational opportunities and vocational counseling.

e. Employment information and help in reaching the proper placement agencies.

f. Recreation facilities.

g. Health services.

State

1. Removal by the State legislature of all residence requirements for welfare, health, educational, and recreational services to transient youth.

2. Designation of a State department, or of a State agency, to be responsible for the administration of Federal and/or State funds for aid to transient youth.

3. Such a State department or agency to be responsible for:

a. Formulation of State-wide plans, policies, and procedures and the collection of information and statistics concerning transient youth.

b. Administration and disbursement of Federal and/or State funds.

c. Supervision of the program in the various communities of the State through counseling and strengthening of existing local agencies or through a direct program.

d. Publication of information regarding laws affecting transients, employment opportunities, housing facilities, and so forth, to be given incoming transients.

Federal

Youthful transiency is not peculiar to California, although no State has yet attempted to meet the challenge it presents, nor is it the problem of the one State or community where the stray youth happens to land. These are the Nation's future citizens and, as such, they need more intelligent understanding and care than they are now receiving from all branches of government. Therefore the Federal Government, and all State governments, should recognize their responsibility for helping to finance the solution of the problems.

Federal agencies concerned with the welfare of children, such as the Children's Bureau, the U. S. Public Health Service, and the Office of Education of the Federal Security Agency; the Department of Agriculture; and the Department of Labor, should stimulate and encourage the dissemination of information regarding the problems of transient youth, and should outline for the use of State legislative bodies, public and private agencies, and citizens' groups, comprehensive plans and procedures to help meet the problem and suggest changes in State and Federal legislation, as needed. Federal programs should include:

1. Financial assistance through grants-in-aid to States to ensure funds for public assistance, which could be used for the return and/or care of transient youth in the community to which they have come, regardless of legal residence.

2. Stimulation and promotion of better arrangements between States, including uniform methods of return and supervision of transient youth in their home communities, and reciprocal agreements between State agencies.

3. Removal of State residence requirements as a condition for Federal aid for relief, health services, or other services to transient youth.

4. Continued interest in the problems of all minor and transient youth, particularly in localities dependent on seasonal workers.

National organizations

National organizations, such as the Y. M. C. A., the Y. W. C. A., the Salvation Army, and so forth, should develop programs on a national level to include the problems of these young people. As national organizations they should encourage their local units in the States to tell youth of the difficulties likely to be encountered when they leave home without definite destination, without sufficient funds, and without family supervision. Such national organizations should also see that local units provide services to nonresident youth, under an over-all community plan to help them adjust more easily into the community of their choice.

Since the study has been made, the findings and recommendations were presented to each community that had participated in it. The need for some central handling of the problems of transient young people has been so accentuated that it appears that funds will be made available in four cities for the establishment of community centers for youths, where agencies responsible for employment, counseling, recreation, health, and housing will be available to young people.

The centers are still too new for us to know whether or not they will prove to be the answer to the transient-youth problem, but at least the committee feels that its study has pointed up the need of a large number of young people in the State, who should be welcomed into its life: and through this study such a center will be made possible.

Reprints available in about 3 weeks

In Memory of Martha Wood

Martha Wood joined the Children's Bureau staff in 1931 and throughout the succeeding years until her death on September 28, 1948, her warm sympathy and understanding and her devotion to the welfare of children illuminated all her relationships, personal and professional. They were the basis of her leadership in developing social-service programs for children. What was happening to children both at home and abroad was always a matter of vital concern to her. She gave of herself selflessly in trying to improve the conditions that handicap children, helping to develop better facilities for their care and protection.

Before she came to the Bureau, Miss Wood had had long experience with family societies and the American Red Cross in the field of family welfare and the protection of family life. After the First World War she spent a year in Serbia with the Serbian Child Welfare Commission. The program of the commission reached back into the rugged mountains of the more primitive regions of that country and involved the finding of children orphaned and homeless as a result of the war. It was typical of the deep personal responsibility she always felt for the welfare of individual children that with an interpreter Miss Wood went out to see for herself where these children were and what they needed, and to arrange proper care and protection for them. This deep concern for people was carried into all other aspects of her later professional life.

During her service to the Bureau she served in several capacities and became familiar with all aspects of the Bureau's program in behalf of children. She was one of the two field representatives in the program of gathering social statistics on a community-wide basis that was undertaken by the Children's Bureau in 1930, and she participated in important local studies of child welfare made by the Bureau. With the establishment of Child Welfare Services under the Social Security Act in 1935, Miss Wood became a regional child-welfare representative and contributed much to the organization of the new program of grants-in-aid. She gave valuable leadership to the several States of the two regions she served in establishing and extending public welfare services to children. Her rich practical experience in Federal-State relationships was the foundation for valuable services as Director of Field Services, Social Service Division, to which position she was appointed. Here again her warm feeling for people permeated all her professional relationships with the field staff.

Her loss to the Children's Bureau, to the Child Welfare Services program, and to her friends and co-workers is an irretrievable one.

KATHARINE F. LENROOT,
Chief, Children's Bureau.

MILDRED ARNOLD,
Director, Social Service Division
Children's Bureau.

FOR YOUR BOOKSHELF

SCHOOLS FOR CHILDREN UNDER SIX; a report on the status and need for nursery schools and kindergartens, by Mary Dabney Davis. Federal Security Agency, Office of Education, Washington. Bulletin 1947, No. 5. 58 pp. For sale by Superintendent of Documents, Government Printing Office, Washington 25, D. C. 20 cents.

The next 10 years will show substantial increase in, and improvement of, programs for young children if professional and lay organizations put their announced policies and programs into practice, says this bulletin. It discusses the present interest in extending schools for children under 6 and tells some of the facts about educational facilities for children under 6 and the organization and operation of the nursery school and kindergartens that was functioning in 1942, when the Office of Education made a survey of these.

Recent popular interest in extension of nursery-school and kindergarten programs the report says, has arisen largely as a result of federally financed programs to serve the children of needy families and, more recently, to provide for the children of war workers.

The increased birth rate, the larger percentage of women workers, and the increased concentration of children in cities are given in the report as factors in the need for extending programs for younger children.

I. Evelyn Smith

WIDENING HORIZONS IN MEDICAL EDUCATION; a study of the teaching of social and environmental factors in medicine, 1945–46. A report of the Joint Committee of the Association of American Medical Colleges and the American Association of Medical Social Workers. Commonwealth Fund, New York, 1948. 228 pp. $2.75.

This book, of interest to all professional workers in the health field, and "must" reading for medical educators, is the result of several years' study by a joint committee of physicians and medical social workers on the teaching of social and environmental factors in medicine. The committee made two fundamental assumptions:

1. "There are three major features of illness—physical, emotional, and social. These are so intimately interwoven in the pattern of disease that they must be considered together, rather than as separate entities. All three must be included in the curriculum if medical education is to provide the student with the knowledge and skills necessary to fulfill the aims of medicine.

2. "The medical student should learn to recognize and understand the social factors in every case, to evaluate them in relation to the medical problem, and to assume responsibility (himself or through others) for the relevant problems as a part of diagnosis and treatment."

The practical application of such principles to medical education are fully discussed on the basis of data presented concerning present methods of teaching in some of the medical schools. Following the brief chapter, "Conclusions and Recommendations," there are 175 pages of valuable documentary material, including case histories, as used for teaching material, selected from the data collected for the study.

Those reading this book may also wish to look at "The Training of a Doctor," the report of the Medical Curriculum Committee of the British Medical Association, London, 1948, where they will find the following key passage:

"The committee believes that, whatever the cost of reconstructing the curriculum, we should return to first principles and so remodel the training of our students that they will base their future practice on an understanding of each patient as a 'whole,' using the resources of the specialties as aids to diagnosis and treatment.

". . . One of the most serious defects in present-day medical training in the clinical period is the failure (1) to regard the patient as a whole, and (2) to teach the principles and practice of general medicine. If the medical practitioner is to treat his patient 'as a whole' he must be taught how to do so in his undergraduate years, and he cannot be properly trained in this conception by the present method of dividing medicine into a number of distinct and separately taught compartments."

Edwin F. Daily, M. D.

ENJOY YOUR CHILD—Ages 1, 2, and 3, by James L. Hymes, Jr. Public Affairs Pamphlet No. 141. Public Affairs Committee, Inc., 22 East Thirty-eighth Street, New York 16, N. Y., 1948. 32 pp. 20 cents.

If every father and mother of very young children could relax enough to follow the suggestion in the title of this pamphlet there would be a tremendous increase in the number of children who enjoy their parents. The ways in which the author shows parents how to avoid overconcern and exasperation are as practical as if he had learned them from experience, which he has—experience with his own children and those in the nursery schools he has directed.

Mr. Hymes knows that parents are only human; this is obvious when he says, "Avoid harsh measures if you can," instead of stopping with a period after "measures." His understanding of the manifold occasions on which children can be puzzling or trying, when parents feel they must "do something" should go far to dissipate this tense attitude among parents, and incline them to look the other way, or, as Mr. Hymes also suggests, "establish a kind of protective deafness and blindness" that will make them feel more like laughing.

Lively drawings bring out some of the features of child development and behavior. An index makes it easier for the reader to refer to topics of special interest.

Marion L. Faegre

PSYCHOSOCIAL MEDICINE, a study of the sick society, by James L. Halliday, M. D. W. W. Norton and Co., New York, 1948. 278 pp. $3.50.

Through its provision of a new insight into the illness of society this book is of exceptional interest in the field of public health. The writer is a prominent British psychiatrist who has been a general practitioner and a public-health administrator and who brings this combined experience to his discussion of the sick society. He develops the idea that, beginning in about 1870 and coincident with an increase in material progress and a decrease in physical illness, there was a decline in the social health of Britain and the United States, as shown in a decreasing fertility, a rising incidence of psychosomatic affections, and profound alterations in social patterns. The book presents these changes in detail and applies to them etiologic and diagnostic considerations. The mining community in England and Scotland is examined as a case in point. It carries to a logical conclusion the use of psychodynamic methodology in the cure of this psychosocial illness.

Some of the highly lucid background material is as important as the development of the entire theme. The discussion of the origin of the psychosomatic affections through consideration of ontogenetic theory and later in terms of epidemiology is an extremely clear and practical application of our knowledge of growth and development. There is a most able discussion of the frustrations of both children and adults; an excellent description of the

decline of mothering; and an explanation both of the part that medicine has failed to play in understanding the psychosomatic diseases and of the needs for changes in medical education to meet the changes in disease patterns.

Stressing the need for a biologic approach to our social distress, Dr. Halliday concludes: "It is uncomfortable to become aware that we live in a sick society and to appreciate that its social sickness is a reflection of our own psychological sickness with its faulty attitudes which are not only emotional but also intellectual. Even more disturbing is the knowledge that social sickness represents a deep-seated biological process tending toward progressive devitalization and even genetic extinction." He holds out the hope, however, that our present imperfect knowledge points a way to improvement and challenges our profession to expand and refine this knowledge.

Henry H. Work, M. D.

• IN THE NEWS

Louisiana Increases Medical Social Services

Four new medical social workers have been added to the Louisiana State board of health in the past year. Consultants are being assigned to the six district offices throughout the State. They will give generalized consultation to staffs of local health units on medical-social aspects of health-department programs.

We Cooperate With Other American Republics

Five training grants in maternal and child health and child welfare were awarded by the Children's Bureau during the fiscal year 1948 to specialists from the other American Republics, under the program of the Interdepartmental Committee on Scientific and Cultural Cooperation, which is carried on under the auspices of the Department of State. The Children's Bureau is one of more than 50 Federal agencies which have been cooperating with other countries of this hemisphere since the 78th Congress enacted Public Law 355, an "act to render closer and more effective relations between the American Republics."

This is a two-way program, under which specialists from the United States are assigned to other countries on request, to engage in cooperative projects or serve as technical advisers to official agencies, and under which specialists in various fields come to the United States for specialized training. The funds for this activity are included in the annual appropriation of the Department of State, which then allocates to each of the Federal agencies the sum required to carry out approved projects for the fiscal year.

Elisabeth Shirley Enochs

Nutrition Bibliography Issued

As its special contribution to the Latin American Conference on Nutrition, which was held in Montevideo, Uruguay, July 18–28, 1948, under the auspices of the Food and Agriculture Organization of the United Nations, the American International Institute for the Protection of Childhood has mimeographed a bibliography on nutrition, which lists the nearly 3,000 books, pamphlets, and magazine articles on nutrition that are in the institute's library.

Items from various countries are included. Among the many from the United States are publications issued by several Federal bureaus, including the Children's Bureau, and a number of State governments, as well as private publishers.

The bibliography is available at the headquarters of the institute, Avenida 18 de Julio 1648, Montevideo, Uruguay.

• CALENDAR

Nov. 20–23—American Academy of Pediatrics. Seventeenth annual meeting. Atlantic City, N. J.

Nov. 26–28—National Council on Family Relations. Chicago, Ill.

Dec. 10–11—American Public Welfare Association. Annual Round Table Conference. December 8, board meeting; December 9, councils of State and local administrators. Cleveland, Ohio.

Dec. 28–30—American Sociological Society. Chicago, Ill.

Dec. 28–30—American Political Science Association. Chicago, Ill.

Dec. 28–30—American Economic Association. Cleveland, Ohio.

Following is the schedule of the area conferences to be held by the National Child Welfare Division of the American Legion:

Dec. 9–11, 1948. Area E—Alaska, Arizona, California, Colorado, Hawaii, Idaho, Montana, Nevada, New Mexico, Oregon, Utah, Washington, and Wyoming. Hollywood, Calif.

Jan. 7–8, 1949. Area D—Illinois, Indiana, Iowa, Kansas, Michigan, Minnesota, Missouri, Nebraska, North Dakota, Ohio, South Dakota, and Wisconsin. Milwaukee, Wis.

Feb. 11–12, 1949. Area B—Delaware, District of Columbia, Maryland, New Jersey, New York, Pennsylvania, Puerto Rico, Virginia, and West Virginia. Baltimore, Md.

Mar. 4–5, 1949. Area A—Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, and Vermont. Boston, Mass.

Mar. 11–12, 1949. Area C—Alabama, Arkansas, Florida, Georgia, Kentucky, Louisiana, Mississippi, North Carolina, Oklahoma, Panama, South Carolina, Tennessee, and Texas. Jackson, Miss.

The Child Welfare League of America has announced the following regional conferences:

Feb. 10–12, 1949. Southern Regional Conference. Montgomery, Ala.

Mar. 17–19, 1949. Ohio Valley Regional Conference. Cincinnati, Ohio.

Apr. 7–9, 1949. Eastern Regional Conference. Atlantic City, N. J.

May 1–4, 1949. Midwest Regional Conference. Chicago, Ill.

June 6–7, 1949. New England Regional Conference. Montgomery, Ala.

In our August issue, the article, "British Experience in the Care of the Premature Baby," by Dr. V. Mary Crosse, carried an illustration that we incorrectly captioned as the bassinet in which premature babies are kept while in the Premature-Baby Unit of the City of Birmingham Maternity Hospitals. The subject of the picture was actually the special heated basket in which premature babies born outside the hospital are carried to the unit by the city ambulance service. We regret this error.

The bassinet itself, which is of white enameled steel, is pictured in Dr. Crosse's book, The Premature Baby, published by J. & A. Churchill, Ltd., 104 Gloucester Place, Portman Square, London. Both of the pictures that we used in *The Child* to illustrate Dr. Crosse's article were reproduced from this book, with permission of the publisher.

Incidentally, we are happy to report that Dr. Crosse was awarded the Order of the British Empire on New Year's Day 1948 for her work in saving the lives of premature babies.

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The list of participants in the Children's Bureau research conferences, which appeared in *The Child* for September, should have included the name of Dr. Robert R. Sears, director, University of Iowa Child Welfare Station.

Photographic credits:
Cover and page 73, Public Health Service, Federal Security Agency.
Pages 70 and 71, Department of Social Services, Commonwealth of Australia.
Page 74, by Dorothea Lange. Library of Congress photograph.

GOALS SET FOR 10-YEAR HEALTH PROGRAM

Federal Security Administrator Oscar R. Ewing has reported to President Truman on plans to better the Nation's health, and excerpts from his report are given on pages 66–69 of this issue of *The Child*. When the President requested this report, he asked the Administrator to set "feasible goals which might be realized by the American people in the next decade." Here are the goals that Mr. Ewing has drawn up for a 10-year health program.

Goal 1: Enough Manpower Everywhere

To increase our supplies of medical manpower until there is enough everywhere in the country to satisfy the health and medical needs of all the people; to do this by expanding and establishing medical colleges, training schools, and teaching hospitals until, by 1960, our annual production of medical manpower in all categories has increased by 40 to 50 percent.

Goal 2: Enough Hospitals Everywhere

To assure that there are enough hospital beds of all kinds everywhere to meet the people's needs, and to finance hospitals so that they may give the highest-quality services; to accomplish this by doubling the number of hospital beds, adding at least 600,000 by 1960; by building such auxiliary health and community centers as are needed, particularly in rural areas; and by uniting hospitals and centers into regional chains so that the most remote regions will have full access to modern and scientific medicine.

Goal 3: An Equal Chance for Health

To assure that every individual, without regard to his economic status, has full access to adequate medical services for the prevention of illness, the care and relief of sickness, and the promotion of a high level of physical and mental health.

Goal 4: Mental Health

To focus attention on mental health as a leading area for medical progress in the last half of this century; to promote research in the field of psychiatry and in the mental-emotional aspects of physical illness; to expand manpower and facilities for both preventive and curative work throughout the country; to accomplish these objectives through use of Federal research and other Federal assistance.

Goal 5: Healthy Maturity

To enable everyone in the Nation to enjoy a healthy, active, and productive maturity, by controlling chronic diseases—the greatest single barrier to achievement of this goal—and by relieving the other physical, mental, and social problems of adult life.

Goal 6: Rehabilitation for Handicapped

To rehabilitate the 250,000 men and women who become disabled through illness or injury every year so that they can be restored to the most nearly normal life and work of which they are individually capable.

Goal 7: A Good Start in Life

To assure to every child in the country the utmost degree of health, a condition in which all his physical and mental powers are functioning at their best; to do this through a national plan that will build progressively toward complete medical care and social, psychological, and health services for all children and mothers in childbirth.

Goal 8: Community Action

Planning and action in every community and every State, directed toward providing the best possible health conditions for all their people, by assuring adequate local supply of needed services, and by organizing the local agencies of health—doctors, hospitals, public health departments, voluntary groups—into effective teamwork for the welfare of the entire community.

Goal 9: Local Health Units

To establish everywhere local health units with full-time qualified staffs adequate to the needs of the population; to increase and improve the training of public-health workers to the end that their numbers shall be doubled as rapidly as feasible.

VOL. 13, No. 5 NOVEMBER 1948

the CHILD

published monthly by the
Division of Reports
CHILDREN'S BUREAU
Managing Editor Sarah L. Doran
Art Editor Philip Bonn

FEDERAL SECURITY AGENCY
Oscar R. Ewing, Administrator

SOCIAL SECURITY ADMINISTRATION
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CHILDREN'S BUREAU
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CONTENTS

Publication of THE CHILD, monthly bulletin, was authorized by the Bureau of the Budget, May 12, 1936, to meet the needs of agencies working with or for children. The Children's Bureau does not necessarily assume responsibility for the statements or opinions of contributors not connected with the Bureau. THE CHILD is sent free, on request, to public officials and libraries. For others, the subscription price is $1 a year. Single copies, 10 cents. Send remittance to the Superintendent of Documents, Government Printing Office, Washington 25, D. C.

U. S. GOVERNMENT PRINTING OFFICE: 1948

DECEMBER • 1948

the CHILD

ATTITUDES TOWARD MINORITY GROUPS

Their Effect on Social Services for Unmarried Mothers

ANNIE LEE DAVIS
Consultant on Minority Groups, Social Service Division, Children's Bureau

MINORITY GROUPS include people lacking the physical, cultural, economic, or social characteristics of those who have achieved status, power, and prestige. Our culture, in spite of its heterogeneity, is a "white, Anglo-Saxon, male, Protestant culture in many respects."

If we accept these characteristics, women, children, organized labor, unmarried mothers, as well as certain religious, non-white and cultural groups are minorities. In this frame of reference, minority denotes lower status rather than fewer numbers.

In trying to avoid the misuse of the term "race" we use the term "culture" to designate groups of people that differ from other groups. By culture we mean the historically developed patterns of family organization, language, customs and traditions, beliefs, worships, sanctions, and repressions that guide and direct human conduct. We regard as cultural groups people from other countries whose customs, family organization, etc., differ from ours; for example, Spanish speaking people, Japanese, and Chinese.

The American Negro has the same basic cultural heritage as other Americans. His cultural patterns have been developed on American soil and in close relation to the white group. An important body of historical material substantiates the fact that there is very little left of his African heritage.

Actually, there is no well-defined American cultural pattern. There are definite outlines as in a common language, family organization, and our theoretical ideas of a democratic society. Within this framework are wide variations—perhaps more variations than conformity when it comes to concepts of marriage and family and the actual organization of our social life.

Whatever the minority group, there are certain common attitudes toward them. These attitudes are the crystallization of some underlying assumptions and traditionally accepted values. Rarely are they based on facts or on experience. The characteristics of a single individual are applied to the group, for example, "Women are ruled by their emotions"; "men should be paid more than women"; "all Negroes can sing"; "Jews are aggressive"; "Indians are silent and sullen."

Many reasons have been advanced to explain such prejudices. They include: A social order based on a profit-making system in which there is a limitless urge to exploit the means of production; economic insecurity expressed in competition for jobs; emotional insecurity that needs a socially acceptable outlet for anxiety and hostility; economically and socially disadvantaged groups, who in order to protect their own egos need to find other groups that they can feel superior to; fear and distrust, physical differences and resistance to change.

The behavior of persons in minority groups is thought of as growing out of inherent physical and biological traits. Actually, it represents an attempt to organize the life and values of the group so as to permit the most satisfying functioning in the social setting to which the group has been assigned.

This kind of generalizing leads to certain expectancies of behavior. For example, Negroes are *expected* to have children born out of wedlock. Indians are expected to be lazy and lacking in ambition. Such generalizations lull us into complacency about many of our social problems.

Minority groups are considered inherently inferior. Traditional patterns of segregation and discrimination are based on this assumption. In turn, the minority groups tend to take over the attitudes and values of the dominant group. Hence they *feel* inferior, insecure, and frustrated.

It is in this framework of attitudes and public opinion that social welfare programs, including those for unmarried mothers, must be projected.

How community attitudes affect services

Social welfare programs for all people are affected by prevailing community attitudes toward dependency, certain types of behavior, and social break-down. The acceptance of broader responsibility by government, local, State and national, for the welfare of people, and the growing consciousness of the responsibility for providing public social services to people needing the service regardless of their economic status, is evidence of the progress we have made. Nevertheless the feeling that people in need are somehow different from those not known to social agencies still persists.

As our understanding of human behavior has increased, our approach to all social problems including unwed motherhood has been on a sounder basis and certainly more humane. However, the social stigma on unmarried mothers still remains and makes the experience traumatic and fearful—fraught with guilt and anxiety. The attitudes of family, friends, the community are the sources from which spring the major social problems faced by unmarried mothers.

Within minority groups, unmarried mothers suffer guilt and shame as in the majority group. In a study made of Indian unmarried mothers known to a voluntary social agency on the West Coast, it was found that the majority of the mothers were nonresidents. In asking why they had come to this city the girls gave the same reasons given by American white girls in similar studies. They were getting away from the hostile attitudes of families, friends, and community or seeking adequate medical care. There are variations in attitude toward unwed motherhood in minority groups as in the majority group. Unwed motherhood among native whites in the hills of Kentucky or the "Jeeters" of "Tobacco Road" does not have the

Based on paper given at the National Conference of Social Work, held Apr. 17–23, 1948, at Atlantic City, N. J.

same connotation as on Beacon Hill in Boston.

To provide adequate services for unmarried mothers, as well as for others, there must be basic public services in local communities where people live. These include broad social services for people in need of the services without regard to economic status, color, religion, or national origin. Medical services and financial aid are also part of these basic public services.

Through the Social Security Act, Federal financial help has been given to the States in providing, extending and strengthening these basic public services.

Frequently communities are not aware that responsibility is not being assumed for all their children, although this responsibility has been given by law to public agencies—and assumed through articles of incorporation by many voluntary agencies. For example, a southern city where Negroes make up 25 percent of the population has had a program of care for white children for 50 years, but it was not until 9 years ago that the community was awakened to its responsibility for Negro children by a study which pointed up their needs.

Maternal and child health services are a resource for unmarried mothers and their babies as well as for other mothers and in general are provided without distinction as to color, religion, or national origin. Unfortunately these services are not available in every local community.

Hospital care during confinement is often a problem for unmarried mothers in minority groups. In large cities, where there are public hospitals, facilities are usually provided for minority groups. In small towns and rural areas, hospital facilities are inadequate for all groups, but almost totally lacking for minority groups. Private hospitals as a rule restrict their services or admit only a limited number of persons in minority groups.

Financial aid is available to minority groups

Aid to dependent children is made available to children without discrimination on the basis of color, religion, or national origin. In general, assistance is also made available to unmarried mothers for their children.

State and local administration of aid to dependent children is influenced by the prevailing community attitudes. Because the majority of persons in minority groups are also generally in the lowest income groups it is sometimes presumed that their needs are less and that naturally they are able to live on less money. Although there are standard budgets which vary from State to State, the application of the budget to specific families is influenced by the attitudes, concern, and conviction of State and local administrators and the community.

Case-work service is basic

Skilled case-work service is basic to adequate social services. Child-welfare services developed in each State under the Social Security Act offer a resource for case-work services to help unmarried mothers work through their difficulties. Unfortunately child-welfare services are not everywhere available. Where services do exist, theoretically these are given on the basis of need without distinction as to color, religion, or national origin. Actually, however, children in minority groups receive less than do other children.

There are many reasons for this but community attitudes are basic to all. When, because of shortage of personnel, child-welfare workers must carry large case loads, the more emergent situations, and those on which the community is demanding action, get first consideration. When communities are complacent or unconcerned about conditions under which children in minority status are living, there is no demand for action. Even though these children are eligible for services and many of them need help, they do not come to the

Children are less apt to be prejudiced and can get along together if their elders do not set barriers and influence their thinking and behavior.

attention of the public child-welfare agencies.

Private family and children's agencies offering services to unmarried mothers vary in their assumption of responsibility to persons in minority groups. Often their articles of incorporation define and limit the groups they serve, for example to persons of Jewish, Catholic, or Lutheran faiths. Nonsectarian agencies, however, usually are not limited by constitution or charter as to color, nationality, or religion. The extent to which they extend their services is dependent upon the enlightenment and progressiveness of their boards and executives. In cities of borderline, northern Midwest, and Western States, usually services are extended to those who need them without question. In some southern cities, however, the needs of Negroes are untouched by private agencies.

Social worker's attitudes are important

Frequently social workers are not aware of their responsibility to serve all children and to give leadership in reaching children in minority groups. They are often just as unaware as the community of the social needs of these children.

In the field of social work developing a professional self involves not only the accumulation of a body of knowledge and skills, but the use of one's *self* in a disciplined way in helping people. This has specific significance in work with people in minority groups.

Social workers like other people are the products of their inherited endowments and their experiences in family and community living. The disciplines of their professional training often bring them into sharp conflict with old ways of feeling and thinking; but should furnish conviction that leads to action on the basis of new knowledge and increased understanding. It is this last step that is so difficult to take in the face of contra-prevailing attitudes.

This is not confined to social workers in the majority group. Persons in minority groups who have taken on the cultural pattern of the majority group are often insecure and hold on to their hard won gains most tenaciously. Assuming the attitudes of the majority group tends to make for closer identification with that group. Often the distance between the lowest and highest social classes within the minority group is greater than the distance between the majority and minority groups on the same economic and social level.

To be effective in a case-work relationship, we need to understand the cultural background of our client. But to understand the client as an *individual*, we must be aware of the meaning his experiences have had for him. Using the words of Bertha Reynolds, this cultural background "is like the backdrop of a stage against which the drama of the individual is to be played."

Availability of facilities is affected by social attitudes

The availability of facilities for minority groups is frequently affected by complacency about social problems within those groups and also by unfounded, generalized thinking. As a result their needs are frequently ignored and disregarded in establishing social-welfare programs. For example, a county judge refused to authorize county funds for boarding-home care for Negro unmarried mothers because he believed that Negroes always care for their children, and therefore, boarding-home care was not needed. Social workers are not free from such fallacious thinking. As late as 1944, a report coming to the Children's Bureau stated: "It was the general opinion of the child-welfare workers of X county that Negro families care for Negro children when something happens to their parents and that the neighborliness and kindliness of Negro relatives far exceed that of white relatives. Therefore, there is very little need for foster care for dependent Negro children." Even though there was some essence of truth here, real concern should compel us to question the kind of care these children receive and should lead us to assume the same degree of responsibility for safeguarding the welfare of these children as for others.

Good foster homes for children in minority groups *can* be found and should be used more often.

Maternity home facilities are inadequate

Few maternity homes include girls from minority groups. Some Mexican, Chinese, Japanese, and Indian girls are accepted in western cities, but not Negro girls. A few maternity homes serve Negro unmarried mothers exclusively.

Some maternity home boards and executives in recent years have attempted to face this situation realistically. The immediate problem is the inadequacy of facilities for all unmarried mothers. What is needed here is reevaluation of maternity home care in terms of its ob-

jectives and the unmarried mothers who will profit from such care. Such planning should precede any extension of maternity home care.

With careful evaluation of individual needs it may be found that some girls will best be cared for in their own homes or with relatives, others in foster homes, and others in maternity homes. Adequate case-work services should be available wherever the unmarried mother is. The experience gained in planning a total program of care for all unmarried mothers will furnish a sound basis for attacking the problem of maternity home facilities for Negro girls.

Another problem in relation to maternity home care for unmarried mothers in minority groups is the belief that the community is not ready to accept the intermixture of races in the homes. Some communities are not. Some have legal barriers against this. But in communities where there are no legal barriers, who can say how far the community is ready to go? Salvation Army maternity homes in Chicago and New Jersey accept Negro girls although other institutions in these communities do not.

Some maternity homes fear that if they open their doors to girls from minority groups, they will become segregated institutions serving only the minority groups. Such fears are unfounded. Young people are less apt to be prejudiced and get along together if their elders do not set barriers and influence their thinking and behavior. If the maternity home has a sound program of services, referring agencies will want this service for white girls, too, and the girls will seek it for themselves.

Foster homes are needed

Foster homes for care of unmarried mothers, especially those in minority groups, are being used increasingly. The difficulty usually expressed in providing such care is in finding adequate homes. True, the majority of people in minority groups are in the lowest income groups, live in the poorest sections in substandard dwellings and with much overcrowding. However, not all persons in minority groups live under these conditions and often it is possible to find homes adequate for this purpose.

Can our failure to find foster homes in the minority group be due to generalized thinking that prevents a factual determination of what is available? How effective are we in making people in minority groups aware of our need for homes? Do these people know what our programs are, and how we can help unmarried mothers?

Sometimes services are not used

One serious problem encountered in providing services for unmarried mothers in minority groups is that they do not use the services. The frequency of independent placements of children of unwed mothers in this country indicates that this problem is not confined to minority groups. The situation, however, may be more acute among them.

The most damaging result of minority status is that these groups are cut off from the main current of community life. They have no feeling that the community will provide for them and little consciousness of the community's responsibility for them. When services are established they are often unaware that the service is there, or that it is for them. At the same time those providing the service may not be aware of this psychological gulf.

Thus to establish a service is not enough. Persons responsible for its administration must see to it that the service is known and help persons in minority groups to use it.

Here efforts must be directed to finding, developing, and utilizing the strengths and leadership within the group. This leadership may be found in just an ordinary person, or it may be the minister, teacher, club woman, or businessman. They should serve on boards and committees, and participate in program and policy making decisions. Through such participation they gain an understanding of agency programs and in turn can help persons in their own group in using the services.

The use of professional personnel from minority groups is also important. This does not mean that only Negroes can serve Negroes, or only Indians can serve Indians. An emotionally mature professionally trained person recognizes the necessity for understanding the client as an individual, within his cultural setting and will be able to form a constructive relationship with any client. However, the agency's inclusion on its staff of persons other than white demonstrates to the community its purpose to serve all people. They not only bring an increase in requests for service from minority groups, but they are an effective educative force with other staff members.

Since community attitudes are determining factors in providing adequate services for unmarried mothers, what is our responsibility as social workers?

We must first have the conviction that community attitudes are not static, that they are dynamic, can be directed, and do change. We must be convinced that we have a responsibility for leadership and for change. We must be aware of our own blind spots and prejudices. We must face the fact that we frequently use the excuse that the "community is not ready" in order to hide our own fears, lack of conviction and courage. We must attempt to see all people as individuals. We must abandon the tendency toward generalizing about groups of people. We must analyze objectively why we are ineffective in a given situation. We must not excuse our failure through blind and wishful thinking that "this is part of the culture pattern, and we dare not disturb it."

We must understand the emotional damage that segregation and discrimination fosters—and we must tell the story in our day by day contacts on the job; to our friends; and to others with whom we are associated. We must assume leadership with our boards and advisory groups in bringing them to the acceptance of their full responsibility. We must take leadership in the integration of persons in minority groups on boards, committees, and staffs. And all of this must be done, not on the emotional basis of race or moral judgment, but on the firm professional basis of giving the best possible service to all persons needing the service.

The cornerstone of social work is the belief in the integrity and worth of the human personality. We believe that the welfare of the individual is the goal of a democratic society. If we are not imbued with the spirit of our profession, if we lack the courage of our convictions, then social work itself has no substance and meaning.

Reprints available in about 3 weeks

WHAT ARE THE TRENDS IN CHILD-GUIDANCE CLINICS?

J. FRANKLIN ROBINSON, M. D.

Director, Children's Service Center of Wyoming Valley, Wilkes-Barre, Pennsylvania

COINED IN 1922, the term "child-guidance clinic" gave a name to an idea that was already 13 years old. The term was used for the first time in demonstrations fostered by the Commonwealth Fund for the National Committee for Mental Hygiene to characterize a threefold clinical service that drew on different professional skills. But much had happened before that.

Dr. William Healy, who founded the Chicago Juvenile Psychopathic Institute in 1909, utilized the findings of psychiatrist, psychologist, and social worker. At the Boston Psychopathic Hospital, which opened in 1912, Dr. E. E. Southard used the term "clinical team" and made use of all the skills available for his patients. In New York, in 1922 at the Bureau of Children's Guidance of the New York School of Social Work and in demonstration clinics conducted by the National Committee for Mental Hygiene and in 1927 at the Institute for Child Guidance the threefold clinical approach became fully effective.

The first psychiatric work with children in the United States emphasized the prevention of delinquency. Healy's work in Chicago and Boston gave it this direction. But the child-guidance clinics rather quickly broadened the base of the work by treating children in their own environments.

The chief aims of the early clinics seem to have been making a thorough diagnosis of the child's difficulties and trying to influence the conditions surrounding him. Dr. Milton E. Kirkpatrick cites another early objective as helping children who showed undesirable behavior and personality traits to achieve "such a quality of mental health that they would be saved from serious mental disorder later in life."[1]

In 1934, Dr. George S. Stevenson and Geddes Smith described the work of the clinic as an attempt to marshal sources of help in a community for certain of its children. These children were in distress because of unsatisfied inner needs or because they were seriously at odds with their environment. Clinical services were given to selected children by means of direct study and treatment by a team made up of a psychiatrist, a psychologist, and a psychiatric social worker. By giving out the results of its first-hand study of some children, the clinic attempted to reveal to the community the unmet needs of many other children.[2]

Many of the problems that the early clinics had to consider were not directly connected with delinquency or mental disease. Difficulties, perhaps of a minor nature, received attention because they occurred frequently, because they were more promising of successful treatment, or because they were potentially serious. During this time the categories of emotional and behavioral difficulties were ascertained from practical experience.

In the child's orbit

A period followed in which clinics emphasized diagnosis. They soon realized that to deal with a child's difficulties they must reckon with his environment. At that time, because placing children in settings different from their usual ones had proved disappointing or impracticable, interest centered on work with persons closest to the child. This interest, perhaps at first aimed at instructing parents, teachers, and others in the child's orbit, soon drew them in as assistants in the effort to help. Then, confronted with the personal complexity of these potential assistants and with their limitations, the clinic team naturally tried to find effective ways of working with them. They focused on treatment methods and much of the work in the clinics during the past 15 years has been developing therapeutic methods and procedures.

The concept of the child has changed

Outstanding in the history of child guidance and a profound influence on clinical methods is the change in our concept of the child. According to Dr. Frederick H. Allen no longer are children regarded as automatons, reflecting unhealthy attitudes of others and incapable of change except as conditions in which they live are changed. In early clinical efforts, Dr. Allen writes, the child was examined and tested mainly to gain information about him rather than to help him directly with his emotional problems. The child was seen as a victim of conditions. Now he is seen as a dynamic factor in his own growth. He takes an active part in the process designed to bring about for him a better adjustment.[3]

Child-guidance clinics have contributed much to the development and refinement of treatment methods, but a discussion of the techniques of psychotherapy is not our immediate concern. We are interested in the way the clinics have utilized the progress made over the years. Differences in practice in the various clinics, it should be said, are not caused by differences in their philosophies of treatment but rather by differences in the method through which collaboration is achieved between the various members of the working team.

That work should proceed with child and parents concurrently is commonly agreed today. Parents and child have had a part in creating the problem for which help is sought and all will have a part in solving it. This does not imply that a clinic cannot admit a parentless child or one away from his family. Most clinics prefer, however, to have responsibility for the child made clear, in the absence of parents. The substitute for the child's parents, like the parents themselves, will influ-

[1] The Organization and Function of the Child Guidance Clinic. The National Committee for Mental Hygiene, 1941.

[2] Child Guidance Clinics, A Quarter Century of Development. The Commonwealth Fund, Oxford University Press, 1934.

Based on paper given at the National Conference of Social Work, held April 17–23, 1948, at Atlantic City, N. J.

[3] Developments in Child Psychiatry in the United States. American Journal of Public Health, September 1948.

Shy and lonely, she needs the help of a clinic as much as does a defiant, misbehaving child.

ence the course of treatment of the child and should be included in the procedure.

Application procedure

The so-called "application procedure" or "initial planning period" brings about the first contact between the clinic and the parents or parental substitutes. If only one parent comes at first, some clinics try to bring both parents into the contact, to take part jointly in the undertaking. In these first visits the parents learn how the clinic works. They may discuss the child's difficulty as they see it, in order to decide whether his is the kind of problem the clinic is ready to help with. In certain clinics the parents return for a second interview or for several so that their decision to accept the clinic's help is thoroughly considered and work with the child may begin under favorable circumstances. Part of the discussion centers on ways to prepare the child for the coming experience.

Distributing professional skills

An initial planning period is arranged in most clinics. Beyond application, differences in practice appear. They may be illustrated by two methods of distributing the skills of the three-member clinical team.

One group of clinics recognize a hierarchy in which the psychiatrist is the key figure in the treatment. The more disturbed or more neurotically involved individual, regardless of his position in the family, is seen usually by the psychiatrist. Thus, the psychiatrist may work with the child while the caseworker works with the parents, or vice versa. Sometimes both parent and child may be under treatment by psychiatrists. This division of work between psychiatrist and social worker calls for an early evaluation of the situation and early planning of treatment.

An illustration of this type of arrangement may be seen in an agency in which the proportion of time given by psychiatrists is less than in most of the clinics. The effectiveness of the case worker as a member of the team is extended by the closeness of the supervision given her work by the psychiatrist. The diagnosis and plan for treatment are made jointly. The case worker administers the therapy with the psychiatrist playing a systematic role in the conduct of cases through regular consultations. Close, continuous collaboration of psychiatrist and case worker underlies the whole clinical program.

Another group of clinics make the basis of their operation the difference between the nature of work with a child and that of work with a parent. According to these clinics the parent, through the application procedure, decides that he will seek help for his child by providing for him a psychotherapeutic experience, a chance to take part in an active process in which he can effect within himself essential change or psychological growth. The parent is drawn into the process himself as he learns that the clinic expects him to play an active role and as he discovers that his own attitude toward the clinic influences the child in his utilization of treatment. Work with the parent, engaged in selecting and using a clinical service for his child, falls naturally into the province of social case work. It is not artificially restricted; it will revolve around the relations of parent and child and will reach into the organization of the parent's personality.

The psychologist in the team

The distinctive contribution of the psychologist to the understanding of children has been in the field of objective evaluation. In addition to standard intelligence, aptitude, and achievement tests, psychologists now use "projective techniques," a major advance in clinical psychology. These projective techniques, perhaps the best known of which is the Rorschach, help not only to determine intellectual capacity but to reveal the structure and functioning of the personality and to make psychiatric diagnoses.

Clinics have long made it a practice to study a child's performance in tests for leads in understanding him. But a change in a test score (when the test is repeated after a time) may show even more. It may show that through treatment a child has been able to achieve a better organization. Projective procedures are especially sensitive to such changes. As confidence develops in these newer techniques they will be used more widely in prognosis. Dependence on such technical procedures can be hazardous, however, unless they are sound and are expertly applied.

Diagnosis today

Some clinics have shifted the emphasis in their diagnostic work. Previously they had looked on diagnosis as a process that oriented their approach to a problem. They could outline treatment or make plans for a child by means of the technical penetration of the problem that was possible through the pooling of professional skills. Clinics learned that parents' incapacity to utilize recommendations called for greater therapeutic efforts. The team looked with less esteem on diagnostic measures that, because of parents' shortcomings, often failed to lead to effective action, but grew to respect more the therapeutic work planned to deal with such re-

sistances. Diagnostic procedures assume a different meaning when they are looked upon as technical services available to a parent in his efforts to understand his child.

When the findings of psychological tests or the opinions of the psychiatrist after a searching interview with the child are given to his parents for consideration, they can speculate on what is to be learned from this step in evaluation. They have elected to have the study made; they will utilize the findings as they are able. A richer use of the observation of the child calls for more extensive work with the parents. Sound diagnostic work can lead to a change in the parents' relations with their child.

Resident centers

Until recently most of the active and effective work of child-guidance clinics has been with out-patients. An application of child-guidance procedure in a somewhat different framework is seen in the resident treatment programs that have recently received increasing attention. The child's admission to the resident center and his temporary stay there are part of a treatment plan. Custody is retained by his parents or substitutes for them and their close contact with him during his stay is a feature of the procedure.

A team of professional workers operates in the resident center much as it does in an out-patient clinic, but another member is added—the resident professional worker whose province is the living setting itself. The parent visits the child regularly, according to a plan, and talks with the case worker each time.

Goals in prevention altered

A changed conception of the difficulties of children has altered our goals in prevention. We are not certain of the relation to psychosis in adult life of the many different behavioral and emotional difficulties of children who come to the clinics. Certainly, few if any of these children will develop psychotic illnesses. Although our ability to detect early malignant changes of personality has been greatly extended by the refinements in interpretation of psychological tests, we cannot predict psychotic changes before they are established in the personality.

That maladjustments in childhood are the forerunners of maladjustments and neurotic difficulties in adult life is well established. But we are on uncertain ground when we try to foretell which children will do poorly in later life.

The difficulties of childhood are so much a part of the growth process, which in turn is subject to many vicissitudes, that an evaluation at a given point cannot divine the future with certainty. We are more concerned with the child's mental health at the moment than with averting disaster in adult life. In child psychiatry the interest in mental hygiene has shifted from preventing or treating mental disease to furthering normal growth.

Child psychology a subspecialty

Child psychiatry has reached the position of a subspecialty in the field of psychiatry. It calls for distinct technical skills that education and experience in adult psychiatry do not give. During therapy a child tends to express himself through play, his natural medium. He is not impelled, as is an adult, by the immediate reality of an interview to consider his troubles directly with the therapist. The clinical symptoms encountered in children are not those seen in adults; they must be learned from direct study of children. With adult patients, events of childhood are considered in retrospect, and a psychology of childhood has been constructed that can be applied in work with adults. But that psychological scheme has not, in general, served as an example to follow in work with children.

When adults close to the child are drawn into the process of treating him, features are introduced into psychiatric work with children that only recently have had a counterpart in work with adults. The fact that the child does not himself start the search for help sharpens the dissimilarity in practice.

Special training, it follows, is necessary for this specialty. The child-guidance clinic, having taken the initiative in child psychiatry for 25 years, is the natural training ground.

All-purpose clinics

A new type of out-patient clinic has recently begun to increase in number. This is the "all-purpose" clinic that serves both children and adults. These clinics, perhaps, will prove to be suited to sparsely settled areas or small communities where operating a full-time child-guidance clinic or separate services for adults would be impracticable. Early experience showed that more of the patients were children than adults. But this proportion may change now that information about the value of psychiatric treatment is reaching more and more people.

As yet these all-purpose clinics can be viewed only as a significant trend. But they will eventually influence the practice of psychiatry. The "team" approach will be used with large numbers of adult patients. This work has been done for some time in a few clinics admitting both child and adult patients and in the collaborative clinical programs established for the armed forces during the war and now organized for veterans.

The all-purpose clinic will influence the field of psychiatry through the qualifications of the workers who man them. Basic professional education in social case work and perhaps in clinical

(Continued on page 93)

In the clinic a child is helped to bring about her own change by taking part in the therapy.

HEALTH OFFICERS SET GUIDES FOR FLUORINE PROGRAM

A STEP toward deriving the greatest benefit in the use of topical fluorides to prevent tooth decay was taken at the forty-seventh annual session of the State and Territorial Health Officers Association meeting in Washington, D. C., in November of this year.

At the meeting the health officers approved a statement of principles for the use of topical fluorides in public dental programs. For some years now intensive research has been under way to take advantage of the action of fluorides in preventing dental diseases. Many studies concerned with the painting of children's teeth with fluoride solutions have demonstrated the fact that tooth decay can be reduced 40 percent by such methods. These studies, at first conducted in laboratories, have since been confirmed by extensive clinical application.

This experience has produced a single technique for the use of fluoride solutions which lends itself admirably to the mass scale approach of this public-health problem.

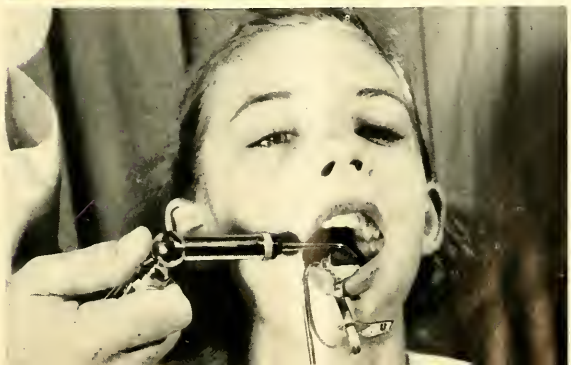
This year the United States Congress appropriated $1,000,000 to the U. S. Public Health Service to demonstrate in States requesting the service the method of using topical fluorides. Three-fourths of the States, the Territories, and the District of Columbia have requested this demonstration service. It is believed that practically all areas of the country will become interested in the use of topical fluorides as a preventive of childhood tooth decay. In the report of the Appropriations Committee of the House of Representatives last year, it was stressed that this demonstration program was to be of a temporary nature, with the States and local communities establishing a more permanent program.

The statement of principles approved by the State and Territorial Health Officers grew out of the recognition that such widespread interest and application of a preventive measure should have a standard or guide in order to be of maximum effectiveness.

In approving the statement, the State Health Officers recommend that all public-health dental programs for children

(Continued on page 93)

Steps in fluoride therapy. From left to right, top row: clean the teeth; block-off teeth with cotton rolls; bottom row: dry teeth with compressed air; apply fluoride solution.



THE TOLL OF RHEUMATIC FEVER

THE importance of rheumatic fever as a cause of mortality in childhood has been stressed in recent discussions from all parts of the world, and particularly in the United States. Every year between 800 and 900 children under 20 years of age die in the United States from acute rheumatic fever, not including the deaths reported from chronic rheumatic heart diseases. Clinical experts say that between 80 and 90 percent of all deaths from heart disease among school-age children (5 through 19 years of age) are due to rheumatic infection. When these deaths are added to those actually attributed to acute rheumatic fever we find that approximately 4,000 children (under 20 years of age) die each year as a result of this disease.

A leading cause of death

Since the decline of tuberculosis and the genuine acute infectious diseases of childhood (diphtheria, scarlet fever, measles, whooping cough, etc.) heart diseases, including acute rheumatic infections, have become one of the leading causes of death among school-age children. If accidents are disregarded, heart disease and rheumatic fever combined is *the* leading cause of death among white children 10 through 14 years of age and white boys 15 through 19.

Mortality rates for the six leading causes of death (in these age groups) are given in table I in the order of the rate for males; the rank of the rate for females is given in brackets. This table shows clearly the relative importance of rheumatic fever and heart diseases at different ages in both races and sexes. Among white children in all age groups the latter conditions are a principal cause of death and are of increasing importance with increasing age.

Among nonwhite children of all ages tuberculosis takes a higher toll than heart disease plus rheumatic fever, as does pneumonia-and-influenza except among the 10–14-year-old girls. Rheumatic fever and diseases of the heart ranks fourth as a cause of death among nonwhite girls 15–19 years of age, with tuberculosis first and diseases of pregnancy second. Early child bearing in this age group of nonwhite girls might also be a contributing factor in the high mortality for both tuberculosis and heart disease.

TABLE I.—Rank of 6 leading causes of death in childhood, 5–19 years, by age, race, and sex. Average annual death rates per 100,000 population: United States, 1939–41

Leading causes of death in order of the rates for the white male	White		Leading causes of death in order of the rates for the nonwhite male	Nonwhite	
	Male	Female (rank in brackets)		Male	Female (rank in brackets)
			5–9 years		
Accidents (169–195)	39. 3	20. 0 (1)	Accidents (169–195)	42. 6	26. 7 (1)
Pneumonia and influenza (107–109, 33)	10. 2	9. 0 (2)	Pneumonia and influenza (107–109, 33)	21. 2	18. 1 (2)
Appendicitis (121)	8. 2	6. 7 (4)	Tuberculosis (13–22)	16. 4	14. 7 (3)
Rheumatic fever (58) and diseases of the heart (90–95).	2. 1 5. 5 } 7. 6	2. 4 5. 6 } 8. 0 (3)	Rheumatic fever (58) and diseases of the heart (90–95).	2. 9 9. 3 } 12. 2	3. 7 9. 3 } 13. 0 (4)
Diseases of the ear, nose, and throat (89, 104, 115).	5. 3	4. 7 (5)	Diseases of the nervous system (80–88).	6. 4	5. 3 (6)
Diseases of the nervous system (80–88)	4. 9	4. 1 (6)	Appendicitis (121)	5. 8	5. 6 (5)
			10–14 years		
Accidents	40. 9	12. 2 (1)	Accidents	56. 2	14. 5 (4)
Rheumatic fever and diseases of the heart.	2. 4 8. 8 } 11. 2	2. 5 9. 2 } 11. 7 (2)	Tuberculosis	22. 3	39. 0 (1)
Appendicitis	9. 0	6. 9 (4)	Pneumonia and influenza	17. 4	16. 3 (3)
Pneumonia and influenza	7. 0	7. 1 (3)	Rheumatic fever and diseases of the heart.	3. 8 11. 3 } 15. 1	4. 2 13. 2 } 17. 4 (2)
Diseases of the nervous system	4. 9	3. 5 (5)	Appendicitis	10. 1	7. 2 (5)
Diseases of the ear, nose, and throat	3. 3	3. 2 (6)	Diseases of the nervous system	7. 8	6. 4 (6)
			15–19 years		
Accidents	74. 1	19. 8 (1)	Accidents	98. 1	21. 1 (5)
Rheumatic fever and diseases of the heart.	1. 6 12. 7 } 14. 3	1. 4 11. 2 } 12. 6 (3)	Tuberculosis	97. 2	159. 7 (1)
Appendicitis	11. 2	6. 6 (6)	Homicide (165–168)	36. 4	15. 2 (6)
Tuberculosis	10. 7	18. 9 (2)	Pneumonia and influenza	30. 0	30. 9 (3)
Pneumonia and influenza	10. 4	7. 5 (5)	Rheumatic fever and diseases of the heart.	2. 2 15. 7 } 17. 9	2. 2 21. 6 } 23. 8 (4)
Diseases of pregnancy (140–150)		11. 3 (4)	Diseases of pregnancy (140–150)		62. 3 (2)

NOTE.—The numbers in parentheses after causes of death are those of the International List, Fifth Revision of 1938; they are not repeated in the different age groups when shown before.

These figures make it plain why the campaign against rheumatic fever must be considered one of the outstanding tasks of public health. In such a campaign it is necessary to know just where the high mortality rates occur and for that purpose we must break down the total crude rates and consider various subgroups of the child population. The Children's Bureau has recently issued a statistical analysis of rheumatic fever mortality[1] in which the death rates are studied on the basis of age, race, sex, and geographic location.

Age, race, and sex differences

The age, race, and sex differences in mortality from rheumatic fever and heart disease throughout the total United States are shown graphically in figure 1; the exact rates on which the chart is based can be found in table II.

The chart shows clearly the rise in the mortality rate in each succeeding age group. This is true for both races and both sexes.

The chart also shows plainly the much higher rates for nonwhite children than white in both sexes and all age groups.

The racial difference in rheumatic fever mortality is not as great as in some other diseases which are aggravated by unfavorable socio-economic conditions, such as tuberculosis, but the pattern is sufficiently strong to suggest that a more unfavorable environment, which doubtless exists for the nonwhite group, tends to increase the risk of dying from rheumatic diseases. That is, rheumatic fever appears to belong to that group of diseases in which, besides the specific etiological agent, the social environment (here reflected in racial grouping) plays an aggravating part.

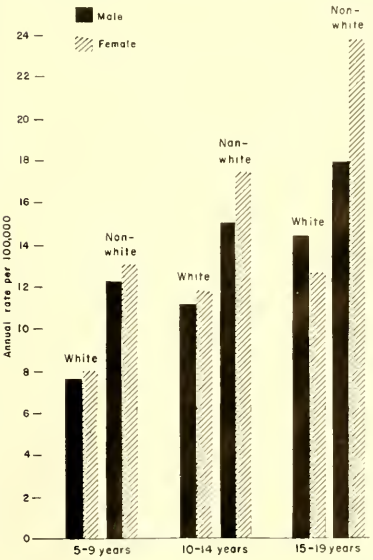
Generally speaking mortality rates from acute rheumatic fever and diseases of the heart, combined, are higher among girls than boys. A marked exception is the much lower rate for white girls as compared with white boys in the 15- to 19-year-old group. The tendency toward higher rates for girls than boys is most pronounced in the age group 15 through 19 years among nonwhite children.

[1] Childhood Mortality From Rheumatic Fever and Heart Diseases by George Wolff, M. D. Children's Bureau Publication 322. Federal Security Agency, Washington, 1948. 66 pp. 25 cents.

TABLE II.—Childhood mortality from acute rheumatic fever, chronic rheumatic diseases of the heart, and diseases of the heart (all forms), by age, race, and sex: United States, 1939–41

Cause of death and race (Numbers of International List of Causes of Death, Fifth Revision of 1938)	5–9 years		10–14 years		15–19 years	
	Male	Female	Male	Female	Male	Female
	Average annual death rates per 100,000					
Acute rheumatic fever (58), all races	2.2	2.5	2.6	2.8	1.7	1.5
White	2.1	2.4	2.4	2.5	1.6	1.4
Nonwhite	2.9	3.7	3.8	4.2	2.2	2.2
Chronic rheumatic diseases of the heart (90a, 92b, c, 93c, 95b), all races	3.2	3.4	5.4	6.0	6.7	6.0
White	3.0	3.2	5.3	5.8	6.7	5.7
Nonwhite	4.7	5.1	6.2	7.1	6.2	7.8
Diseases of the heart (all forms) (90–95), all races	6.0	6.1	9.0	9.7	13.1	12.4
White	5.5	5.6	8.8	9.2	12.7	11.2
Nonwhite	9.3	9.3	11.3	13.2	15.7	21.6
	Ratios: Nonwhite to white					
Acute rheumatic fever	1.4	1.5	1.6	1.7	1.4	1.6
Chronic rheumatic diseases of the heart	1.6	1.6	1.2	1.2	.9	1.4
Diseases of the heart (all forms)	1.7	1.7	1.3	1.4	1.2	1.9
	Ratios: Male to female					
Acute rheumatic fever:						
White		0.9		1.0		1.1
Nonwhite		.8		.9		1.0
Chronic rheumatic diseases of the heart:						
White		.9		.9		1.2
Nonwhite		.9		.9		.8
Diseases of the heart (all forms):						
White		1.0		1.0		1.1
Nonwhite		1.0		.9		.7

FIGURE 1.—Death rates for acute rheumatic fever plus diseases of the heart in white and nonwhite children, by age and sex: United States, 1939–41. (Average annual death rates per 100,000 in each specified group.)



Geographic differences

Mortality from acute rheumatic fever and diseases of the heart varies among the geographic divisions of the United States. For both white and nonwhite children, the death rates for acute rheumatic fever plus heart diseases are below average in the South while in the Northeast, especially in the Middle Atlantic division, they are significantly above average. In the Pacific division the death rates are as low as in the South and significantly below the country's average, while in the Mountain division they are exceptionally high for the white children in all age groups.

This geographic tendency becomes still more evident when rates are considered separately for white and nonwhite children or the regional differences in the proportion of white and nonwhite children are discounted by adjustment of the rates.

The crude and the adjusted rates for the geographic areas of the United States, per 100,000 children, 5 through 19 years of age, are as follows:

	Crude rates
1. Middle Atlantic	16.3
2. Mountain	15.3
3. East North Central	12.4
4. South Atlantic	11.1
5. New England	10.5
6. East South Central	10.2
7. West North Central	9.3
8. West South Central	8.8
9. Pacific	7.7

	Adjusted rates
1. Middle Atlantic	17.4
2. Mountain	15.3
3. East North Central	13.3
4. New England	12.0
5. West North Central	9.9
6. South Atlantic	9.8
7. East South Central	9.6
8. West South Central	8.4
9. Pacific	8.3

Further studies are needed to show how much of what appears to be a climatic-geographic difference in mortality may be due to differences in degree and character of urbanization or other factors. The Children's Bureau report, Childhood Mortality From Rheumatic Fever, makes comparisons of the individual States within the geographic areas. A few of the more outstanding facts of the report may be mentioned briefly.

In New England, industrial and densely populated Massachusetts shows a distinct tendency to higher mortality and is closer to the neighboring Middle Atlantic area than the other States in New England. There are no striking differences among the Middle Atlantic States except that among white children in New Jersey the boys have the lowest rates for this whole region while the girls as consistently have the highest. Why white boys should have more favorable rates in New Jersey than in New York or Pennsylvania while white girls have the most unfavorable rates among the three States cannot be answered without further study. In Indiana there is a similar situation. Here the white boys have the lowest rates and the white girls the highest to be found in the five States of the East North Central area (Ohio, Indiana, Illinois, Michigan, Wisconsin).

In the Mountain States the mortality rates in Arizona for heart disease are consistently below the group average and as consistently above in Utah. Population factors can hardly explain these differences. Similar findings have been mentioned by former investigators of the rheumatic-fever problem and they merit a more thorough examination. In particular the high mortality for 15- through 19-year-old white boys in Utah, highest among all States, challenges the attention of public-health workers and local physicians. On the Pacific Coast the highest mortality rates among white children for heart disease are found in Oregon and the lowest in California. This cannot be attributed simply to a northern climate, since Washington has better rates than Oregon, nor to overcrowding, since population density is lower in Oregon than in California; the contrast should therefore be studied more intensively locality by locality.

The trend in rheumatic fever mortality since 1920

The fact that rheumatic fever and heart disease has now become one of the leading causes of death among children is due to a decline in other childhood diseases and not to an increase in rheumatic fever mortality rates. Table

TABLE III.—Death rates for acute rheumatic fever and diseases of the heart in children, 5–19 years, by age, race, and sex: United States death registration States, 1919–21, 1929–31, 1939–41, 1942, 1943, and 1944

[Average annual rates per 100,000]

Years, cause of death	White						Nonwhite					
	5–9 years		10–14 years		15–19 years		5–9 years		10–14 years		15–19 years	
	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female
1919–21												
Acute rheumatic fever	4.4	4.1	4.5	5.3	3.5	3.6	2.3	2.2	2.5	3.7	3.7	3.5
Diseases of the heart	14.2	15.2	18.8	23.9	23.2	23.3	8.2	10.1	14.8	18.1	22.1	30.7
1929–31												
Acute rheumatic fever	3.0	2.9	3.1	3.2	2.3	2.3	2.1	2.9	3.3	3.2	2.7	3.2
Diseases of the heart	9.6	10.6	13.4	16.4	18.5	18.4	9.6	10.4	12.9	15.0	21.1	28.2
1939–41												
Acute rheumatic fever	2.1	2.4	2.4	2.6	1.7	1.4	2.9	3.7	3.8	4.2	2.2	2.2
Diseases of the heart	5.5	5.6	8.8	9.2	12.7	11.2	9.3	9.3	11.3	13.2	15.7	21.6
1942												
Acute rheumatic fever	1.8	1.8	1.8	2.1	1.3	1.4	2.6	3.7	3.8	3.6	2.1	1.9
Diseases of the heart	4.3	4.4	6.9	6.9	11.4	10.4	7.5	8.7	12.0	10.9	15.0	19.8
1943												
Acute rheumatic fever	1.6	1.4	1.7	1.9	1.3	1.4	3.3	2.9	2.8	2.6	1.8	2.7
Diseases of the heart	4.0	4.6	7.0	7.7	11.4	9.8	4.8	7.1	11.5	13.5	15.5	23.6
1944												
Acute rheumatic fever	1.7	1.5	2.0	2.1	1.9	1.4	2.9	3.8	3.3	3.8	2.8	1.4
Diseases of the heart	3.9	4.2	7.5	7.1	11.1	8.6	6.3	7.2	11.5	12.7	15.3	18.1

III shows the death rates for acute rheumatic fever and for diseases of the heart by age, race, and sex for the period between World War I and World War II.

The most impressive fact brought out by table III is the distinct decrease in mortality among white children, reported over the past decades. This decrease is in the neighborhood of 70 percent for the age groups 5 through 9 and 10 through 14, and of 60 percent for the age group 15 through 19 years.

However, the story is very different for nonwhite children. Among these children no consistent downward trend is visible, except in the oldest age group 15–19 years; even this decrease is far behind that of the white adolescents in both sexes and amounts to hardly more than 25 percent from 1919–21 to the last report in 1944. It appears from the reported figures that in the early period (1919–21) the nonwhite children had very low death rates, lower indeed in most instances than those of the white children. This result is contrary to later experience in the detailed study of the 1939–41 period, when the nonwhite children almost everywhere demonstrate consistently higher death rates from rheumatic fever and heart diseases than the whites.

How far the statistics reflect the true epidemiological trends of rheumatic fever among white and nonwhite children during recent decades is open to question. It is improbable that the socio-economic conditions, including availability of medical services to nonwhite children, was so superior in the earlier period as to bring out these results. The most plausible explanation of the apparently increased mortality rates would seem to be that for nonwhite children the reliability of the medical diagnoses and their reporting on the death certificates has increased.

All combined (crude) rates necessarily obscure finer differences by age, race, and sex. Therefore age-race-sex specific death rates are given in the Children's Bureau report for the individual States; they provide more detailed information of special interest for the local State health authorities.

Child Guidance Clinics

(Continued from page 88)

psychology can be applied more interchangeably in work with children or in work with adults than can basic education in psychiatry. Two years of accredited training in adult psychiatry are required as preparation for advanced training given in child-guidance clinics in psychiatry for children. If his preliminary training in work with adults has been adequate, the psychiatrist trained in a child-guidance clinic can work with both child and adult patients. But because there are few so trained and because pressure from the public to have clinics established gives so powerful an incentive, some all-purpose clinics may start to operate under the direction of psychiatrists who are not satisfactorily grounded in work with children.

Interest, funds, but few specalists

A critical issue confronts the child-guidance clinic. The new, keen public interest in seeing psychiatric services extended, combined with greater availability of funds for establishing them, has created pressure for more children's clinics. Some communities, disregarding the advice of experienced counselors and undismayed by the shortage of qualified specialists, are employing workers unable to operate efficiently in a child-guidance clinic.

Fortunately, a source of help on standards is at hand for communities wanting to build a service. Recently organized, the American Association of Psychiatric Clinics for Children will serve as an accrediting agency. Acting with the Division on Community Clinics of the National Committee for Mental Hygiene, this association will provide criteria that communities may use in planning and operating clinics.

The importance of sound planning and building cannot be too strongly urged. Otherwise the high level of child-guidance practice, the source of the clinics' success for a quarter of a century, may not be maintained universally.

Reprints available in about 3 weeks

Guides for Fluorine Program

(Continued from page 89)

should routinely include the topical application of fluoride and, since it is a preventive measure of great promise, it should be available to all children in the area.

Recognizing that the services of dentists are already at a premium and so urgently needed to provide corrective dental care which only dentists are qualified to render, the statement suggests that auxiliary personnel be trained to provide the fluoride treatment. In this way, the maximum number of children can be reached.

To further promote efficiency and economy of the topical fluoride program, it was felt the service could best be provided in places where it was possible to reach groups of children, such as schools, clinics, and institutions.

The Health Officers believed that two administrative methods would be feasible: (1) Adding the topical fluoride applications to existing dental clinic services; and (2) Organizing new programs devoted exclusively to the use of fluorides, so that the services could be made available to children in areas that do not now have highly developed dental programs.

In starting a community program, the statement of principles points out, a series of 4 sodium fluoride applications should be given to every child in the community. Thereafter, in order to provide protection for the permanent teeth during the period of changing dentition, the series of 4 applications should be repeated at approximately 3-year intervals.

The statement concludes with the suggestion that a technic which has been adequately tested should be rigidly followed.

The Children's Bureau, responsible in the Federal Government for administration of grants to the States for child-health services, has already approved the use of these grants for providing this essential dental service for children. It is anticipated that the States will request increasing amounts of child-health grants to help finance State-wide protection of children's teeth by the new method.

Progress Notes on State Action

TAP ROOTS of action toward the 1950 White House Conference are spreading wider and deeper over the country. "Nation-wide" begins to have real meaning as the concept of a mid-century stock taking of America's children grips the minds and imaginations of people: as States and communities set to work to stimulate action toward objectives to be achieved by 1950.

At this time 35 States have some form of planning committee or council for children and youth, some officially established, others on a voluntary basis. At least three other States or Territories are in process of organizing a planning group.

Since January 1, the following State councils and commissions either have been established or strengthened:

Arizona Youth Council.
Colorado Council for Youth, Inc.
Kentucky Planning Committee for 1950 White House Conference.
Illinois Council for Children and Youth.
Michigan White House Conference Preparatory Committee, and Michigan Interdepartmental Committee on Child Services.
Oregon Governor's State Committee on Children and Youth.
West Virginia Committee on Planning for Children and Youth.
Wisconsin Committee on Planning for the White House Conference.
Wyoming Council on Children and Youth.

A number of States, at the call of their Governors, have held State conferences on children and youth. Some of these are specifically called and so designated, in preparation for the 1950 White House Conference. Others are that in essence but not so designated. They all denote a growing awareness of the necessity to build stronger services for children and youth.

The result of this coordinated planning for children is a growing unity of effort between the public and private agencies, between professionals and laymen—a partnership in the common cause of children.

Michigan in action

"Children are everybody's business." With that as its title, the Governor of Michigan called a conference on children and youth in Lansing, November 11, 12, and 13. In June, Governor Sigler had appointed two committees: One the Interdepartmental Committee on Child Services, made up of 12 State agencies dealing with children, and the other the White House Conference planning committee. These two committees did the spade work for the conference.

Success of the conference, and all reports confirm that it was a success, was due, as one commentator puts it, "to cooperation and communal brain work." Nearly 800 persons jammed the general sessions; there were over 600 registered delegates. During the conference, 66 sessions were held, 7 regional conferences, and 21 discussion groups. Prof. Jay Bryan Nash of New York University was the keynote speaker at the opening and the closing sessions.

The conference laid the foundation for State-wide action for children. Karl F. Zeisler was chairman of the planning committee for the conference.

Maine starts planning

The Maine State Conference of Social Work, meeting in November at Bangor, instructed the chairman, Dr. Burton Taylor, of the Department of Sociology of Bowdoin College, to take action, in cooperation with other groups, to further Maine's planning for the White House Conference. An informal planning group met in conference for this purpose on December 3.

Ohio conference in process

Too late to be reported, a State-wide conference on children and youth was held in Ohio, December 15. The conference expected to recommend organization of a permanent State committee with a paid director. Gov. Thomas J. Herbert, in calling this conference, wrote:

"In this period of world-wide uncertainty and change, it is imperative that we in Ohio give serious thought to the preparedness and the conservation of our human, as well as our material, resources. Inasmuch as the children and youth of Ohio are the State's basic resources, we must assay how adequately the needs of children are being met at the present time and must plan to improve facilities for child care so that every child will reach adult life equipped to fulfill his duty to society....

"Such steps will be in line with planning for the White House Conference for Children which will be called in 1950 for the purpose of evaluating the child-care facilities and programs in operation in the various States."

North Carolina looks at children

At a meeting September 28, which brought together lay citizens, including a group of young people, and representatives of private and governmental agencies, Gov. R. Gregg Cherry designated the North Carolina Conference for Social Service as the agency to sponsor North Carolina's participation in the 1950 White House Conference. A steering committee was set up to assist the president and secretary of the North Carolina Conference for Social Service to carry forward plans and initiate action.

The impetus for this conference came from the report, "What of Children in North Carolina?" issued in 1947 by the State Planning Board's committee on services for children and youth. The North Carolina Commission on Statutes Relating to Domestic Relations, authorized by the legislature in 1947, has been at work drafting bills embodying the recommendations made in the report.

Reports made at the September conference presented concretely a picture of how North Carolina has embarked upon the task of finding out about the status of its children and services to them and what it proposes to do about bettering the services.

A committee on projects outlined a wide range of projects for study and promotion. The first step is to be a stock-taking survey by each community of its resources, facilities, programs,

and needs for children. This would be a follow-up of the comprehensive State survey on tax-supported services for children and general social and economic facts about children reported under the title of "What of Children in North Carolina?"

A proposed program of legislation affecting children, to be presented to the 1949 State legislature, was also outlined to the conference.

This conference was one of a series planned to insure State-wide discussion of the measures proposed.

State and county action in Texas

Texas has set in motion a county-by-county program in preparation for the White House Conference. The Texas Committee for Children and Youth held its annual meeting November 16 in Houston. Howard Lackey, Executive Secretary of the Community Council of San Antonio, was elected chairman of the committee. Mrs. George H. Abbott, former chairman, will continue to be responsible for work with the county White House Conference chairmen.

Kansas council meets

The Kansas Council on Children met in Topeka, October 27. The council is working with the Juvenile Code Commission to interpret the commission's legislative proposals to the public.

Initial planning in Iowa

The Division of Public Health Education called a meeting October 6 to consider: "How Will Iowa Prepare for the 1950 White House Conference on Children and Youth?" Mr. King Palmer of the Iowa Mental Hygiene Society was selected as chairman of the preliminary planning committee and Miss Esther L. Immer of the State board of social welfare, secretary.

Minnesota youth conference

Minnesota's fine State-wide program for youth was reported on at the Governor's State Conference on Youth held in St. Paul, October 18–19. In calling the meeting, Gov. Luther W. Youngdahl said, "No more important meeting has been called since I became Governor."

This is only a partial reporting of the action in behalf of children and youth which is going on in the Nation. Citizen groups are at work reviewing the needs of children and preparing measures to be presented to State legislatures meeting in 1949.

Patterns of action begin to emerge throughout the country in preparation for the Midcentury White House Conference on Children.

The character of planning toward the conference is essentially democratic. Its main strength lies in local initiative and experience to be gained through diversity. While plans and procedures vary, one common purpose binds all who engage in this national enterprise—to strive to reach the maximum that every State and community, and the Nation, can achieve for the good of children.

• QUOTE-UNQUOTE

"There is a growing group of agricultural migrants in this country who are largely responsible for the high quality of fruits and vegetables that we find in our markets the year round. Many of these migrants move in family groups and their children often help on the crops. Our States and communities have not yet built up a system of assuring to these migrant families the protection and services that are available to the permanent residents of communities. Frequently, mothers have little care at the time of childbirth, children have no health services, little schooling and no access to community recreation facilities; and their families are housed in unsanitary shacks and camps, often without adequate protection from the weather. Progress has been made, but the problem of providing conditions and services for these families comparable to those we consider essential in a good American community has not yet been attacked with sufficient vigor by communities, States, or the Federal Government."

Program for Children and Youth, adopted by the National Commission on Children and Youth, January 28–30, 1948.

"America is faced with a solemn obligation. Long ago we promised to do our full part. Now we cannot ignore the cry of hungry children. Surely we will not turn our backs on the millions of human beings begging for just a crust of bread. The warm heart of America will respond to the greatest threat of mass starvation in the history of mankind."

Julia C. Lathrop, 1919.

• CALENDAR

Dec. 27–29—American Statistical Association. Cleveland, Ohio.

Dec. 28–30—American Sociological Society. Chicago, Ill.

Dec. 28–30—American Economic Association. Cleveland, Ohio.

Dec. 28–30—American Political Science Association. Chicago, Ill.

Area conferences, National Child Welfare Division, American Legion:

Dec. 9–11, 1948. Area E—Alaska, Arizona, California, Colorado, Hawaii, Idaho, Montana, Nevada, New Mexico, Oregon, Utah, Washington, and Wyoming. Hollywood, Calif.

Jan. 7–8, 1949. Area D—Illinois, Indiana, Iowa, Kansas, Michigan, Minnesota, Missouri, Nebraska, North Dakota, Ohio, South Dakota, and Wisconsin. Milwaukee, Wis.

Feb. 11–12, 1949. Area B—Delaware, District of Columbia, Maryland, New Jersey, New York, Pennsylvania, Puerto Rico, Virginia, and West Virginia. Baltimore, Md.

Mar. 4–5, 1949. Area A—Connecticut, Maine, Massachusetts New Hampshire, Rhode Island, and Vermont. Boston, Mass.

Mar. 11–12, 1949. Area C—Alabama, Arkansas, Florida, Georgia, Kentucky, Louisiana, Mississippi, North Carolina, Oklahoma, Panama, South Carolina, Tennessee, and Texas. Jackson, Miss.

Regional conferences, Child Welfare League of America:

Feb. 10–12, 1949. Southern Regional Conference. Montgomery, Ala.

Mar. 17–19, 1949. Ohio Valley Regional Conference. Cincinnati, Ohio.

Apr. 7–9, 1949. Eastern Regional Conference. Atlantic City, N. J.

May 1–4, 1949. Midwest Regional Conference. Chicago, Ill.

June 6–7, 1949. New England Regional Conference. Portsmouth, N. H.

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THE ROAD AHEAD TO CHILD HEALTH

Most of us are aware that we are living in a period of great change; in a new age growing out of man's skill in discovering facts about the physical and biological world and his ingenuity in applying them. We cannot escape from the fact that knowledge in this realm has surged far ahead of knowledge in the social sciences of the nature of man himself. Enormous benefits to our health, to our social and economic status, may accrue; but so too may our destruction come out of scientific advance. What we have failed to grasp is that the use to which these tools are put by man will be determined by his social philosophy, by his emotional reactions and behavior.

Man has learned that he must nurture the land if it is to be productive, he must tend it carefully and wisely, he must fertilize it. So must our health programs develop from cultivation at the grass roots. The vigor of our State and national health services will depend upon the nurture we give to local health activities.

What man will be like when he comes to maturity will depend to a great extent upon the nurture we give him in his infancy and early childhood, upon the opportunities and guidance we give him in his adolescence and youth, upon the strength we develop in the relationship of parent to infant, parent to child, child to child. In a very real sense the child is the touchstone. What we do for him we do for all mankind; what we do for adults, we also do for children.

Children must become the focus of our everyday thought, of our economic and social planning, and of our domestic and foreign policy. Suppose we limit ourselves to child health. What does this mean in the field of health?

There are some parts of the maternal and child health program we know how to do fairly well, but we are not doing them well enough nor extensively enough. I refer specifically to the basic preventive program in which the physician and the nurse advise the mother, either in the physician's office, or in the health center, or in the school or clinic, or at home, about the health and general care of herself, her baby, and her children. Hundreds of thousands of parents still do not have this help; few parents get the best help we know how to give, including pediatric, nursing, dental, nutrition, and social advice; very few receive the kind of mental advice that pediatric workers trained in child development are equipped to give.

Basic maternal and child health services, however, are not enough. Many additional services are urgently needed. Mothers must have complete and adequate maternity care available to them everywhere. Infants, especially those prematurely born, all preschool children, and children of school age through adolescence must have freely available to them, wherever they live, not only preventive health services, mental as well as physical, but also all necessary care when they are sick, and child guidance and psychiatric service when required. Unless we have these services, we cannot produce a generation of young people who are fully mature and healthy in body and mind, who are emotionally secure and able to give more than is asked for, to face success and frustration with equanimity, to be self-reliant, to cooperate with their fellows, to take their place in a democratic society as thoughtful, responsible citizens concerned with the common good, and to "live harmoniously in a total changing environment."

This is the kind of harvest for which we must now cultivate our soil and husband our resources.

Martha M. Eliot

Associate Chief, Children's Bureau

VOL. 13, No. 6 DECEMBER 1948

the CHILD

published monthly by the
Division of Reports
CHILDREN'S BUREAU

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Publication of THE CHILD, monthly bulletin, was authorized by the Bureau of the Budget, May 12, 1936, to meet the needs of agencies working with or for children. The Children's Bureau does not necessarily assume responsibility for the statements or opinions of contributors not connected with the Bureau. THE CHILD is sent free, on request, to public officials and libraries. For others, the subscription price is $1 a year. Single copies, 10 cents. Send remittance to the Superintendent of Documents, Government Printing Office, Washington 25, D. C.

U. S. GOVERNMENT PRINTING OFFICE: 1948

JANUARY • 1949

the CHILD

ORGANIZED LABOR SPEAKS IN BEHALF OF CHILDREN

OUR Nation's children and their future welfare are an important concern of both of the two great labor organizations, the American Federation of Labor and the Congress of Industrial Organizations. This is shown in the policies adopted at their recent annual conventions. The AFL met at Cincinnati, Ohio, November 15–23, and the CIO at Portland, Oreg., November 22–26. We are presenting here some excerpts from these policy statements.

AMERICAN FEDERATION OF LABOR

". . . *Aid to children.*—We believe that all children, regardless of race, residence, or family income have the right to whatever health and welfare services and medical care they need for wholesome growth and development and that it is the responsibility of the Federal Government to help the States and communities meet these requirements. We favor raising the amounts available for payments to the States to whatever sum is needed to meet the requirements of an adequate maternal and child-welfare program."

. . . . . .

Resolved, That the AFL . . . hereby condemns the continuance of child labor, demands the restoration by Congress of the cuts in the appropriation for the Federal child-labor programs, urges the improvement of State child-labor laws and school-attendance laws, and commends the work of the National Child Labor Committee in its efforts to abolish child labor in America and promote the opportunities of all children for healthy and normal development.

. . . . . .

Resolved, That the 67th convention of the AFL, in behalf of suffering humanity, go on record as supporting the Crusade for Children.

The convention upheld the recommendation of the committee on resolutions, which stated: "We . . . must await the outcome of the United Nations deliberations as to whether this campaign will be continued or not. In the event there is an affirmative decision in the matter by the United Nations we will, of course, give our wholehearted support toward a campaign to aid the world's needy children."

. . . . . .

Resolved, That the AFL . . . reiterate its previous stand in favor of Federal aid to education and urge all affiliated bodies actively to support legislation to make Federal assistance to the schools a reality, and be it further

Resolved, That the AFL . . . support the recommendation of the AFL Permanent Committee on Education that Federal aid to the schools should not be less than one billion dollars annually, to be distributed to the States on a basis of need.

CONGRESS OF INDUSTRIAL ORGANIZATIONS

We believe that the first right of citizenship in a democracy is to grow throughout childhood in good physical, emotional, and social health and security.

A major objective of the CIO is to

help achieve this right for all children through policies and measures insuring:

1. Family incomes that can buy a good living and that are protected against the hazards of unemployment, sickness, disability, accidents, and death;

2. Homes that are well-designed and well-built, with adequate space for wholesome, happy family life;

3. Physical and emotional health: For mothers during pregnancy and childbirth; for children from birth through adolescence, including protection against avoidable illness and complete medical and hospital care when ill or crippled;

4. Good schools, with teachers well-paid and not overworked, to provide education that is suited to the capacities and interests of every child, that respects and develops each child's personality, that keeps him free of taboos and superstitions, and that helps to prepare him to take his place in a democratic society as an informed, responsible citizen;

5. Recreation and opportunity for association through youth organizations that help in building children physically and increase their understanding of and tolerance for others;

6. Protection against too early and unsuitable employment of children that stunts their physical, emotional, and social growth, and deprives them of their right to develop through play and study;

7. Child-welfare services that supplement the care and encouragement that parents give their children, through providing such services as day care for children of working mothers, and that bring skill and understanding to children who are neglected or delinquent, or who have lost their parents;

8. Communities so designed and organized that children are protected from hazards and are given every possible encouragement to develop as healthy, happy human beings.

Great numbers of our children today are forced to grow up in families and communities that are unable to provide these opportunities.

A weekly income of $50 today buys only a meager living for a father, mother, and two children. And yet 60 percent of all our children are in families that have even less than $50 a week.

Slum areas in every city and shanties along country roads are testimony to the wretched and unwholesome housing in which we force millions of children to live and grow. Nine million dwelling units today lack even running water.

The Federal Security Agency's Children's Bureau tells us that nearly 200,000 babies are born each year without any medical care, and many more are born to mothers who have had little or no medical supervision during pregnancy.

Each year some 20,000 babies die needlessly.

Well over 100,000 children are victims of cerebral palsy, a condition that need not be tragic for them or their parents, but that often is tragic because most parents cannot afford the treatment these children require to help them become self-reliant, productive people.

Each year 100,000 children are stricken with rheumatic fever or rheumatic heart disease, another extremely expensive handicap.

Before parents can get the medical and surgical care their sick and crippled children need, they are required, in many States, to declare themselves paupers.

On the sickness-prevention front we pretend we are providing public-health services for children, but in half our counties there is not a single public school where a doctor gives the children a health examination. In a great many other counties the school health examination is a sham. Hundreds of thousands of children are found to have poor hearing, poor eyes, poor teeth, but little or nothing is done to make sure that their ears and eyes and teeth are put in good condition.

Child-labor problem is serious

Against the exploitation of children by employers we have enacted State and Federal child-labor laws and have devoted many years of high-minded preachment and propaganda. But today the fact remains that thousands of children are forced by economic conditions to seek paid employment in the years when they should be at school and at play. And we permit employers to profit from the low-paid labor of these children because the laws we have enacted are patently weak and the moneys appropriated by our lawmakers are shamefully inadequate. America has slipped backward in the fight against child labor; in 1948, three times as many 14- and 15-year-old children were employed as were employed in 1940.

Establishment of the principle of free public education in the early years of our Republic is one of the achievements of organized labor of which we are proud. But after more than a hundred years of public education we must recognize that our children go to school, if at all, in overcrowded schoolrooms where they are taught by disgracefully overworked, underpaid, and for the most part unorganized teachers. The grudging tax-supported expenditures which we make for the education of our children provide a sorry commentary on our professed faith in the value of an enlightened democracy when stacked up against the vast sums which, without protest, are poured into soft drinks, horse races, moving pictures, slot machines, and other forms of commercialized recreation.

Although for many years we have known that the wealth of a few States and communities is derived from the poorly paid labor and products of other parts of our country, we have not yet made the decision that by Federal aid to education the United States shall give a guarantee to all our children that the cost of their public education shall be borne by the wealth of the Nation as a whole, and that those born in low-income communities or to parents of restricted means shall enjoy an equal chance at the educational opportunities which the richest Nation in the world is well able, but has not yet seen fit, to provide for all of them.

We have not devoted enough attention to the election of boards of education in cities, counties, and States. The character and quality of courses and teaching have suffered. In too many instances children of union members have been given antilabor and antiunion propaganda in public schools.

In recent years, labor generally, and CIO unions particularly, have taken an active part in such elections and have aided in the election of boards that more accurately represent the interests of the entire community. But more must be done.

Nearly a million children come to the attention of the courts during a year, a shocking indication of the wretched conditions under which many children are forced to grow up. In some States, children held for court action are housed with adult malefactors and criminals in jails while they wait to have the courts act on their cases. Thousands of children, needing the comfort and security of foster homes, are denied them because of penny-pinching public policies. Day-care services for children of working mothers are all but nonexistent, although the number of working mothers is almost twice as great as it was before the war.

Recreation programs inadequate

No community in the country has an adequate recreation program for its youngsters, or adequate recreational facilities. Most cities, by their neglect, force children to play in danger of life and health, and many cities—by design—separate children by race or color in their schools and on their playgrounds.

Parents, by themselves, cannot possibly provide all the services and opportunities for growth that their children need. This is a job for communities, States, and the Federal Government, working together with parents and with voluntary organizations; therefore, be it resolved:

That the CIO, through its National, State, and local organizations, lend its full support to the expansion of public programs to insure:

1. Family incomes adequate to provide support and security for children as well as adults. Benefits under old age and survivors insurance, unemployment compensation, and public assistance must be extended to all and increased to take into account the needs of the children involved. Study should be made of family allowance programs to see whether such a program should be adopted in our country.

2. Housing and community developments designed to meet the needs of children, as well as parents, for good living.

3. Health services and medical care for all children. This is a first charge upon our Nation. Services for the prevention of diseases and for the treatment and care of all illnesses and crippling conditions in children should be everywhere available to all families through insurance and general taxes, so that no child in the country is forced to go without care wherever he happens to live or whoever his parents happen to be. No parent should be subjected to the indignity of a means test in order to get care for his child. Present Federal and State funds for extending and improving these services and this care must be drastically increased.

4. The trend toward more child labor must be stopped and reversed. The employment of children for profit is too costly a drain upon our strength as individuals and as a Nation to be tolerated. It must finally be abolished by prohibitions that really prohibit and by adequate funds for enforcement, as proposed elsewhere in these resolutions.

5. Every child must have real access, wherever he is, to as much education as he and his parents want and as he can assimilate. It is more than ever true that we are in a race between education and catastrophe. Education for each child must be of the best quality. It should include, in addition to the standard curricula, courses in the history and present activity of labor unions, farm organizations, and cooperatives, fairly presented by teachers who are adequately paid and supported by boards of education who represent all the people of the community. Wealth must be taxed where wealth is, to educate children where children are, as proposed elsewhere in these resolutions.

6. Social services for all children in need of special help. Day-care services for children must be available to all working mothers everywhere. Communities must be staffed and equipped to find wholesome, happy care for every orphaned, neglected, or delinquent child who cannot be cared for at home. Children with serious emotional problems must have special provisions made for them. We are determined to cut down the juvenile-delinquency rate. We know that happy, healthy children do not get into trouble with the law. Federal and State funds for child-welfare services must be drastically stepped up.

7. More research on the needs of children. For the sake of both parents and communities, we need to know more about what makes for healthy, happy growth in children; how parents can do a better job for their children; how to cure and prevent many illnesses; how to improve our services for children. We can learn more if we have a well-supported plan of research in child growth and development. Certainly our understanding of children's needs is as important as our need to understand and control atomic energy. Not less than $5,000,000 a year should be invested by the Federal Government in research in child life.

We pledge ourselves that our next generation of citizens shall have a better start in life than we or any earlier generation has had. Whether by a total program of conservation of human rights or step by step, we intend that this Nation shall move ahead in behalf of all children. In this cause we solicit the support and allegiance of all citizens to whom a child is important, in himself and as the hope of a better tomorrow.

Resolutions against child labor

Whereas, 1. The Congress of Industrial Organizations holds that the children of America are the most precious asset of the Nation;

2. There are now more than two million boys and girls 14 to 17 years of age still at work in the factories, fields, and service industries of our land—more than twice the number employed before the war;

3. Many of these children have left school to become full-time workers;

4. The employment of these children is detrimental to health and well-being, and deprives them of an opportunity for normal growth, development, and education; and

5. Child labor is cheap labor, and is a constant threat to the wage standards of organized labor;

Now, therefore, be it resolved, that:

1. We support the National Child Labor Committee's program for effective State and Federal child-labor laws in order to guarantee to American boys and girls freedom from exploitation;

2. We work for legislation which will eliminate harmful child-labor employment in the factories, fields, and service industries in our Nation; and

3. We support adequate appropriations for the enforcement of State and Federal child-labor laws.

Cutting tobacco with a sharp, hatchet-like knife is dangerous work for this 12-year-old boy.

Fair Labor Standards Act Seeks to Protect Children in Agricultural Jobs

WM. R. McCOMB

Administrator, Wage and Hour and Public Contracts Divisions, U. S. Department of Labor

RURAL CHILDREN have a right to go to school, and the Fair Labor Standards Act recognizes that they need to be protected in that right. Though, in general, the act exempts employment in agriculture from its provisions, it applies the 16-year minimum age for general employment to employment at agricultural work during the periods when a child is required by State law to attend school.

The United States Department of Labor has now had 10 years of experience with this provision. It has carried out inspections in some areas where the State school-attendance laws were sufficiently strict to result in coverage under the child-labor provisions of the Fair Labor Standards Act. And despite difficulties in enforcement under the present wording, the Department has made well over 200 child-labor inspections of farms, including the inspections made during the fall of 1948.

This experience has demonstrated that the general principle of protecting the right of children to go to school against the competition of employment is entirely sound in its application to agricultural employment, and that some improvement in conditions can be made under the present law. However, it has also shown that this law has many loopholes that permit employment of children at agricultural jobs during school hours, when they ought to be in school.

Limiting the application of the child-labor provisions of the act to the periods when the State law requires a child to be in school makes the Federal law fall far short of meaning that rural children shall be freed from farm employment during the hours that schools are in session.

State school-attendance laws, upon which the application of the Federal provisions depends, differ widely. These laws provide for varying exemptions and permit local discretion in applying these exemptions, and in some States make employment at agricultural work a legal excuse for the child's nonattendance at school, or require him to attend school for only a part of the school term. All this has resulted in unequal application of the Federal provision and, in effect, in nullifying it in many places.

Obviously the present Federal standard does not affect in any way children employed at agricultural work during vacation and outside school hours, nor does it protect children below the compulsory school-attendance age from undesirable work at too early an age.

Moreover, the minimum age applies only during the harvest season, because of the 30-day clause in the law, which makes shipment of goods in interstate or foreign commerce illegal only if under-age children have been employed within 30 days prior to the removal of the goods from the place where they are produced. Because of this technicality, work done prior to the harvest usually would be excluded.

In addition to these limitations in the law, difficulties are encountered in mak-

ing inspections of farms to find children who are employed illegally. These difficulties are more varied and far greater for inspections made in agriculture than for inspections made in industrial and commercial establishments.

There are, first, the physical difficulties in getting to the farms, and in finding out where the children are working. Secondly, there are usually no records to aid in identifying the children who are or have been employed, or to prove their ages.

Moreover, community and State support of enforcement measures are of even more importance here than in enforcing general coverage not dependent on a State school law, because, lacking such support, there is danger that State exemptions to school-attendance requirements may be widened.

Furthermore, Federal regulation of employment of children in agriculture lacks the support of State labor legislation in many places. Most State child-labor laws do not offer any protection to child workers in agriculture; even now, in 1948, most of them either exempt, or fail to cover, farm work entirely, or set no minimum age for such employment outside school hours.

In spite of limitations in the application of the Federal child-labor provisions as they are written, and in spite of the difficulties, and the consequent costliness, of making inspections, some educational work on the child-labor standards of the act for agriculture and some inspectional activities for compliance have been undertaken successfully. (A full account of an inspection program in the Arizona cotton fields, conducted when the Children's Bureau was administering the child-labor provisions of the Fair Labor Standards Act, appeared in the April 1942 issue of *The Child*.)

This boy is skipping school to work for a grower of sweetpotatoes. The grower is thus violating the child-labor provisions of the Fair Labor Standards Act, for he is employing a child of school age while the school-attendance law of his State requires the child to be in school.

Inspection findings—the first 9 years

Child-labor inspections were made of 193 farms during the first 9 years of administration of the act. Child-labor violations were reported for 106 of these farms, which produced a wide variety of crops and which were located in 8 States (Arizona, Alabama, California, Florida, Maryland, New Jersey, Texas, and Virginia) and in the Territory of Puerto Rico.

The total number of minors under 16 years of age thus found employed illegally, that is, during the hours they were required to be in school by the laws of the State in which they were working, was 567.

Almost 2 out of 3 of these illegally employed children (351 out of 567, or 61.9 percent) were under 14 years of age. Some were as young as 7. A few children even younger were also found helping with the work in the fields during these inspections, but their employment could not be considered illegal because they were younger than the minimum age established by their State laws for compulsory school attendance in the States where inspections were made.

During these 9 years, children were found working on many different crops. They worked in the fields at such jobs as picking cotton, harvesting strawberries and cranberries, pulling radishes, cutting asparagus and spinach, and picking beans and tomatoes.

Jobs of this kind require long hours of arduous, repetitive work, but inspection reports under the Fair Labor Standards Act do not show hours worked, owing to the fact that the wage and overtime provisions do not apply to agricultural employment.

Inspection findings—1948

Preliminary reports on agricultural child-labor inspections made during the fall of 1948 show an additional 89 boys and girls under 16 years of age found employed during periods when they were required by State law to be in school. These boys and girls were working on 35 farms in 4 States (Alabama, Michigan, Nebraska, and New Jersey).

One out of every two (46 out of 89) of these boys and girls under 16 years of age was under 14. The ages of the 89 children illegally employed were:

Age	*Number of children*	*Age*	*Number of children*
15	14	10	4
14	29	9	2
13	8	8	3
12	14	7	3
11	11	6	1

These boys and girls were working as follows while they were required by State laws to be in school:

- 33 topped sugar beets—age range from 7 through 15 years.
- 22 harvested potatoes—age range from 7 through 15.
- 19 picked cotton—age range from 9 through 14.
- 15 harvested such crops as tomatoes, beans, flower bulbs—age range from 6 through 14.

Penalties and court action

The basic policy in administering the child-labor provisions has been to obtain compliance, in the first instance, through educational means; but court action becomes necessary at times. Such action in situations involving children

employed in agriculture has been brought in five cases over the past 10 years.

Three of these cases were civil suits to obtain an injunction against future violations, one was a criminal prosecution, and one was a suit charging contempt of court. This last case was against an employer who had illegally hired children after an injunction had been issued forbidding him to violate again the child-labor provisions of the Fair Labor Standards Act. As a result of this action, the employer was fined $150.

The following two examples illustrate the kinds of situations where legal action is taken.

Cotton.—A grower of cotton in Arizona was found during an inspection to be employing 27 boys and girls between 8 and 16 to pick cotton during periods when, according to Arizona school-attendance laws, these children should have been in school. Fourteen of the 27 children were under 12 years of age—7 were 11, 2 were 10, 3 were 9, and 2 were 8. Some children under 8 were also found working in the fields, but these were not illegally employed, for they were below the Arizona compulsory school-attendance age. This grower was notified of the violations and warned of the penalties involved.

When another inspection was made 2 months later he was again employing illegally some of the same children, and he had hired others illegally. Legal proceedings brought after the second inspection resulted in a court injunction against him, prohibiting future violations.

Cranberries.—A New Jersey cranberry firm was found, during an inspection, to have employed 14 boys and girls under 16—4 under 10, 1 only 7—to pick cranberries during periods when the New Jersey law required them to be in school. One 6-year-old who helped his mother was not employed in violation of the Federal child-labor provisions, as he was younger than the minimum State compulsory school-attendance age. Total fines of $3,000 were assessed against the corporation and two of its officers for violation of the Federal law.

What the present program means

These stories are of situations where the standards of the State school-attendance law were high enough to make the Federal provisions meaningful. In many other States the same kind of work of children goes on during the hours schools are in session but is entirely legal. Children work long hours, all day and every day during the peak harvest season, when weather and crop conditions permit. For instance, complaints were received in September of this year from one State where it would have been pointless to make an inspection because children in that State are required to attend school for only five-sixths of the school term.

It is encouraging, however, that the inspections that have been made and the few legal cases that have been brought have had an effect that has extended far beyond the particular farms and areas visited.

For instance, in a year following inspections in the cotton fields of Arizona, the head of Arizona's labor department, after visiting the cotton fields, wrote to the United States Department of Labor: "Our labors have borne fruit. School authorities report good attendance, and early picking is being done entirely by adults."

In inspections made in the cranberry bogs of New Jersey during 1948 no violations were found. It was significant that the cranberry and blueberry growers had been notified by their growers' association about Federal and State child-labor provisions as they affect agricultural employment. Undoubtedly they were also influenced by their knowledge of the large fine, already reported, that had been assessed against officials of a New Jersey firm of cranberry growers.

What of the future?

These inspection findings in regard to agricultural employment under the child-labor provisions of the Fair Labor Standards Act, limited as they are, when set against the background of known conditions of such work, show that the present child-labor coverage is far from giving all children hired to work at agricultural jobs a chance to go to school full time.

A change in the Federal law is needed which will prevent employment of children in agriculture during any hours that schools are in session, in order to give to the boys and girls now growing up the benefit of this aid to their opportunity for education—the education they need to become men and women adequate to the responsibilities that will confront them. The Administrator of the Wage and Hour Division is recommending such a change in his annual report to Congress.

Reprints available in about 4 weeks

Weeding carrots may not be hard work for a little while, even in the hot sun, but as a day-long job it is very hard on children like these. Since the carrots cannot be shipped within 30 days of the work, these children are not protected under the Fair Labor Standards Act.

FLUORIDE TECHNIQUE DEMONSTRATED IN RADIO PROGRAM

February 7 will be National Child Dental Health Day and has been so proclaimed by the President of the United States.

As part of the celebration of that day, we present a radio script, written by Sophia Podolsky of the Division of Reports, Children's Bureau. The program was first broadcast in Washington. This script may be adapted for local-community use.

ANNOUNCER. Hello, ladies and gentlemen. I'm kind of excited about the story we're going to hear today. You've probably been reading a lot lately about a new discovery to help solve the tooth-decay problem in children.

We all have teeth . . . and most of us have trouble with them.

Now it looks as if science has come up with a substance that promises to reduce our tooth trouble.

At least that's what I've been hearing. And so we've asked Dr. John Fulton, Dental Services Adviser of the Children's Bureau, to come in and tell us something about it. What's the story, Dr. Fulton?

FULTON. Well, scientists have discovered that when a compound of a substance called fluorine is painted on the teeth, it makes them more resistant to decay.

ANNOUNCER. You mean it's as easy as that . . . you just paint something on the teeth, and it slows up tooth decay? This I'd like to see!

FULTON. That won't be hard. I've brought my daughter Sally along because she's about due for another treatment. Maybe we can give you a demonstration right here in the studio. It won't be as handy as a dental office, but I think we can give you a good idea of how we give the treatment.

ANNOUNCER. Hello, Sally. I'm pleased you could come.

SALLY. How do you do.

ANNOUNCER. Your dad says you're due for another fluorine treatment, Sally, and he's willing to do it right here in the studio. Is it all right with you?

SALLY. Sure! I'm used to dad's enthusiasm for fluorine. Besides, I want my teeth to be as nice as possible.

FULTON. Up into the chair with you! The first thing we have to do is clean the teeth.

ANNOUNCER. While you're cleaning Sally's teeth, would you tell us when you first started to use fluorine to help prevent tooth decay?

FULTON. We started these treatments back in 1944, when Sally was about 7 years old. It was about that time that the first reports on painting the teeth with sodium fluoride were published. Three different studies appeared at about the same time. Dr. John Knutson's report was one. John is the senior dental surgeon in the Federal Security Agency's Public Health Service who perfected the technique. As I said, these reports appeared in the literature at about the same time. And this, mind you, was several years before any rash of information appeared in the magazines and newspapers and on the radio.

ANNOUNCER. That's something that puzzles me, Dr. Fulton. How come we haven't heard about this fluoride until lately?

FULTON. It's true that there was good evidence from all those early studies that applying fluoride solution to the teeth reduces decay, but there were a lot of questions that had to be answered before it could be recommended for general use.

ANNOUNCER. What kind of questions, Dr. Fulton?

FULTON. Well, we didn't know how strong the solution should be. Or how many times the teeth had to be painted. Or how long the effects of the fluorine would last. There's been a lot of study made on local application of fluorides since I first began to use it. Now those questions have been answered, and we can go ahead. That's why the magazines have mushroomed with fluorine stories lately.

ANNOUNCER. Just what is this method, Dr. Fulton?

FULTON. Actually, the method that is known as the topical or direct application of fluorides starts with cleaning the teeth. The teeth are then dried, are painted with a 2-percent solution of sodium fluoride, then dried again, and rinsed. The solution is applied four times, at the rate of one or two a week. That completes the treatment. But we clean the child's teeth the first time only. I'm doing it again on Sally just for the sake of demonstrating a complete treatment.

ANNOUNCER. I've been wondering, Dr. Fulton, whether anyone can paint his own teeth with fluorine. From the sound of it, it doesn't seem to take much equipment and it certainly looks easy enough.

FULTON. It sounds easy, all right. But a fluoride treatment is not something you can get by walking into a drug store. It's a *dental* operation and must be performed by someone trained in dentistry.

ANNOUNCER. It looks as if you've got those teeth all cleaned and polished. What next?

FULTON. Then we rinse the teeth off. There we are . . . all rinsed. How do your teeth feel, Sally?

SALLY. Clean as a whistle, dad!

FULTON. Now I block the teeth with cotton rolls. This is so that they will be

absolutely dry before I paint on the fluoride solution.

ANNOUNCER. While you're busy with that cotton, Dr. Fulton, would you tell us when these fluoride treatments should begin?

FULTON. The Public Health Service is recommending that the first application should be made when the child is about 3 years old. This will protect the baby teeth. Then when he is 7, to catch the newly-cut incisors and first molars. Again at 10 years, to protect the cuspids and bicuspids. Finally, at 13, to save the second molars. And that about covers the waterfront.

ANNOUNCER. I'm beginning to see, Dr. Fulton, why this requires trained hands. Now that the teeth are thoroughly dried, it's time to paint on the fluoride solution, isn't it?

FULTON. A good paint job, and that's the whole treatment, except to let the teeth dry for 3 minutes. You will notice that the solution I'm using looks like water. It leaves no stain on Sally's teeth.

ANNOUNCER. It beats me how easy all this looks, Dr. Fulton.

FULTON. It is easy, but detailed and precise.

A fluoride treatment is a dental operation and must be given by someone trained in dentistry.

I should point out here that no matter how early you catch the teeth, these treatments do not guarantee 100-percent immunity to tooth decay. The finest results that I know about is about 40-percent reduction in dental decay over a 3-year period.

Well, it looks as if we're all blocked off now, and ready for the fluoride.

ANNOUNCER. While we're waiting for Sally's teeth to dry, how about telling us exactly how these applications reduce decay?

FULTON. We don't know exactly. The investigators believe there are several possibilities. I'll tell you the most likely one. But before I do, let me explain what causes tooth decay in the first place. There are certain enzymes in the saliva that act on sugar to produce an acid. That's how tooth decay starts. Now it has been found, after much research, that the presence of fluorine in a tooth makes that tooth less soluble in mouth acids.

ANNOUNCER. Could you tell us a little about what fluorides are and where they are found?

FULTON. Well, fluorides are chemical salts of the element fluorine, which occurs very widely in nature. It appears in soils, in rocks, and in some ground waters. Hard waters from deep wells contain fluorine . . . surface waters do not. Fluorine is also a constituent of normal tooth structure. Which reminds me, I guess the 3 minutes for drying are about up. Now to get rid of these cotton rolls . . . and then to flush the mouth with water. And that's it. The whole operation takes about 9 or 10 minutes. How are you doing, Sally?

SALLY. Just fine, dad. I feel as if I'll *never* have trouble with decay—at least not for a couple of years.

ANNOUNCER. I've been wondering, Dr. Fulton, does the treatment only work with child patients? What about old fangs like mine? Will fluorine help *me* fight decay?

FULTON. So far, all but one of the many tests reported have been on children. But investigators are beginning to test the application of fluorides to the teeth of adults, and we're most anxious to see what the result will be. I've had my own teeth treated, just in case.

ANNOUNCER. We still have a little time left, Dr. Fulton; and I have a few more questions.

FULTON. Good, let's have them.

ANNOUNCER. All through this demonstration I've been wondering how the fluorine therapy developed. How did scientists happen to discover that fluorine had the power to reduce tooth decay?

FULTON. And with that question you're squaring right up to a dramatic and exciting story that's been unraveling for a long time.

ANNOUNCER. How far back does it go?

FULTON. In the nineteenth century a Scottish doctor, Sir James Crichton-Browne, had the idea that the absence

of fluorine in the diet might have something to do with bad British teeth.

ANNOUNCER. Did anybody sit up and take notice?

FULTON. Nope, I'm afraid not. The time wasn't quite ripe. It wasn't until 1908 that interest in fluorine was revived. And in a very odd way. A dentist by the name of McKay—Frederick McKay, out in Colorado Springs, Colo., noticed that a lot of his patients had ugly brown mottling of the teeth. He called it Colorado brown stain. And he set out to find the cause of it. The first thing that he and his colleague, G. V. Black, found was that the stain appeared only among people who had spent their childhood in Colorado Springs. Folks who had moved in as adults were free from it. And the children who grew up, and finally moved away from Colorado Springs, never lost the stains. Dr. McKay studied a nearby community, and found that the citizens were free from mottling. He compared the two communities, and they were identical in every respect, save one—that was the source of the water supply. Colorado Springs got its drinking water from the Pikes Peak watershed; the other community did not. He had the water analyzed, but nothing was found that was known to stain the teeth.

FULTON. For 20 years Dr. McKay and Dr. Black combed for clues. Wherever they went they got samples of the drinking water and analyzed it. But no luck. In 1928, the search led to Bauxite, Ark. In Bauxite there was a great deal of mottling . . . but in a small community not more than 4 miles away, the teeth of the townspeople were unstained. Then the usual water supply in Bauxite was cut off, and water from the other town brought in. *The new teeth that started growing were unstained.* Dr. McKay was convinced that the mottling was caused by something in the drinking water. This time the water was analyzed by technicians who really knew their business.

ANNOUNCER. . . . and they found fluorine in the water! Am I right? Say, this is as good as a whodunit.

FULTON. Fluorine it was . . . and McKay started working on the new clue. All these years his research had been thwarted by faulty water analyses. Now it was 1931 . . . and he had started his search in 1908. He started sampling all over again. Sure enough . . . he found that in communities where there was mottling, there was fluorine in the drinking water. Where there was no mottling, there was no fluorine. He returned to the Pikes Peak watershed, and found that it contained a mineral that was rich in fluorine.

ANNOUNCER. And so the reason for Colorado brown stain was found. So far, it appears that fluorine is the villain of your piece. What's the sequel, Dr. Fulton?

FULTON. It didn't take long for the villain to turn into a hero. McKay noticed that people who had mottled teeth didn't have many cavities.

ANNOUNCER. Aha! So they pinned it on fluorine. By George, that Scotsman's hunch was right, after all.

FULTON. They pinned it on fluorine indeed! By now the field was wide open. The secret life of fluorine was being probed by a score of investigators . . . and it didn't take them long to prove that fluorine had an attachment for tooth enamel . . . that one could paint it onto the tooth structure and achieve a 40-percent decrease in tooth decay.

ANNOUNCER. Could you tell us about one of the tests that led to the painting of teeth with fluorine, Dr. Fulton?

FULTON. To do that, we'll have to skip from Bauxite, Ark., in the year 1928, to Brockton, Mass., in the year 1941. Ten-year-old Susie Johnson climbs into a dentist's chair. The dentist cleans her teeth, much as I cleaned Sally's a few minutes ago. Then he starts painting them with fluorine. But instead of a complete paint job, Susie's dentist only swabs one-half of her teeth with the colorless solution. Susie gets several more such treatments. Three years later, Susie returns. Her untreated teeth show nearly twice as many cavities as the painted ones.

Twenty thousand children have now been tested—and with the same results.

ANNOUNCER. I hope that every child can have this treatment, Dr. Fulton. Are we headed in that direction, do you think?

FULTON. That's our hope. And there's no reason why we can't. Painting the teeth with sodium fluoride should be a routine technique from the time a child is 3 until the last molar is expected. We've made a start.

And the Public Health Service has set up demonstrations in most of the States, so that the people can see for themselves how effective the fluoride treatments are. It's your Government's way of translating into action one of the most dynamic trends in modern dentistry.

ANNOUNCER. Our thanks go to Dr. John Fulton of the Children's Bureau, Federal Security Agency, and to his daughter Sally for demonstrating the direct application of fluorides. I think you'll agree with me that fluorine has been well worth waiting for.

And now it is my great pleasure to present Dr. Leonard Scheele, Surgeon General of the United States Public Health Service.

Dr. Scheele, we'd like to know what you think of the demonstration of fluoride treatment that you have just seen.

SCHEELE. To my way of thinking, the discovery of the fluoride method, just demonstrated by Dr. Fulton, is the greatest advance in dental research that has been made during this century.

My own children are receiving these treatments. And I think that all the Susies and Sallies and Joes and Johnnies should have the same opportunity for increased dental health.

When it comes right down to it, there are only two persons who can see that a child's teeth receive this essential treatment—his father and mother. That's why we're asking all parents to join together with their dentists, their State and local health departments, school boards, and civic groups, and start a fluoride program in their community. It is by working together in this way that parents can give their children a degree of dental health such as no previous generation has enjoyed.

ANNOUNCER. Thank you, Dr. Scheele. I'm sure that all our listeners will agree that it is up to the parents of the country to see that the application of fluorides becomes the routine treatment that Dr. Scheele believes it should be. And I think that we can start in right now—all of us—and celebrate National Child Dental Health Day by getting a fluoride program going in our own community.

Reprints available in about 4 weeks

The map of Finland will be dotted with health houses when the program for establishing them in that country is complete.

FINLAND BUILDS HEALTH HOUSES

DR. PAAVO KUUSISTO, *Medical Consultant to Suomen Huolto (Finland Relief): Mannerheim League for Child Welfare; and the Finnish Red Cross, Helsinki*

FINLAND, like other countries, is trying to solve its social problems in relation to its own specific characteristics. This is true of its attitude toward public-health work. The March 1948 number of *The Child* (pp. 138–139) gave a general view of the functions of maternal and child-health work in Finland. I shall now try to inform you in greater detail of how we in Finland try to further the progress of this work throughout the country, with the help of the so-called health houses, or health centers.

Finland covers an area a bit smaller than its neighbor Sweden. It is slightly less than twice the size of New England, but it has only 4,000,000 inhabitants—31 per square mile. Over one-fourth of these live in cities or the more densely populated industrial communities, and the remainder in rural regions. Characteristic of the country is its great number of lakes and forests. About 60,000 lakes, grouped into several large lake districts, break up the country and make traveling in some regions awkward. Finland has, furthermore, a long coast line, with a huge archipelago. The population of the countryside is scattered; the distances from one farm or village to another are extremely long and are very difficult to traverse.

Administratively this sparse countryside population is divided into about 470 rural counties. In general, the population of these counties ranges from 2,000 to 15,000. In the southern and western parts of the country the counties are relatively small in area, but in the east and the north they are large. In each county there is a village or small town that is the administrative center of the unit. Usually it is a historic old church village, or some other village that is a traffic center in the county. In order that public-health work may reach every citizen in this sparsely inhabited country, the work is carried on from many small centers of activity.

Finland's birth rate decreased during the half century before World War II, as it did in other countries. At the same time the infant death rate also diminished, as is apparent from the following:

	Births per 1,000 inhabitants	Deaths of infants per 1,000 born alive
1891–1900	32.2	142
1901–10	31.1	124
1911–20	25.4	112
1921–30	22.2	92
1931–40	18.6	72

During and after World War II the birth rate rose somewhat. In 1941–45, it was 21; in 1946, it was 26; and in 1947 it was 26.4. Infant mortality has consistently shown a tendency to diminish, and for the 6-year period 1941–46 it was only 60.3. This figure, however, is much greater than the infant mortality for the same period in Finland's western neighbor countries, particularly Sweden and Denmark.

In Finland the war wiped out almost the same number of human beings that are born in that country in a year. Therefore, some opposition to public-health work which existed before the war was changed quickly into a lively and sympathetic interest in everything that would tend to lengthen life, build health, and lessen the threat of death.

During 1943 and 1944 the Finnish Diet passed laws reinforcing public-health work, some of which perhaps would not have been accepted during the good years of peace.

According to the present law every county must in certain prescribed ways provide public-health services and must care for its sick. Every county must have at least one licensed doctor of medicine and one or more public-health nurses and midwives. In order to strengthen and enforce public-health work every county must establish a maternity and child-welfare clinic, where medical advice and care is given free of charge. The State gives monetary aid toward this.

Necessities provided for new baby

The Finnish Government subsidizes these activities in the poorest counties. Not a single mother or child need go without necessary advice. Every expectant mother without means receives from the State, as a gift for the coming child, his first clothes and other necessities, a so-called motherhood-equipment package, similar to a layette, except that owing to serious clothing shortages many of the items are made of paper.

Thus in theory. But in practice? Can Finland, a country impoverished by the wars, sparsely inhabited, suffering from excruciating housing conditions, offer an activity of this kind, complete with building, rooms for clinics, and living quarters for personnel? All efforts have been made with this in view, but it has become apparent that the public-health clinic work done by the doctor, the public-health nurse, and the midwife succeeds completely only when

a special house built just for the purpose of this work is available in every county. Large counties would need several of these buildings set up in various places within their boundaries. In Finland we call a house of this kind a health-welfare house, that is, a health house (Finnish—terveystalo).

The Finnish health house is a central building for community health-welfare work, and includes:

(*a*) A sufficiently roomy apartment for the clinics, including two or more examination rooms, a waiting room, an isolation room, and so forth.

(*b*) Living quarters for the public-health nurse, the midwife, and the homemaker. (For a description of homemaker service in Finland see *The Child*, July 1948.)

In the relatively large waiting-room is placed an exhibit, used as teaching material for maternity and child-health work. In the same room lectures are given for the mothers and the nurses. In addition there are storage rooms for the convenience of the staff in the cellar, or in a separate building, and last but not least a Finnish bath (sauna) without which no real Finnish house in the country is a home.

Back in 1925 the Mannerheim League for Child Welfare founded the first child-health center, in which the activities of a 'health house' were outlined. The principles of these houses in their present form were established in 1944 by the Finnish State Medical Board, which drew up standard-type plans. The Mannerheim League has since developed blueprints of several different types of plans, which can be chosen from according to needs and conditions prevailing.

Plan adaptable to local needs

The health house is intended to be used only for the examination of healthy mothers and children, as is specified in the law regarding public-health clinics. The doctor is in attendance once or twice a month, depending on the number of people living in the county. The nurse and the midwife receive applicants there more often, and on designated days. Every mother and child is examined, and advice is given. All is free of charge.

The health house is the county's central health clinic, and the so-called secondary clinics serve as branches in the isolated parts of the county. In this manner the network of the health-house activity reaches every citizen.

This Finnish baby is brought regularly to the terveystalo, or health house, for examination.

At present there are not enough health houses in existence, and the public-health work in many places is still done in temporary rooms. The first new-type health houses were finished in 1946. The lack of money and of building materials has slowed up the building process. This year and last year, however, the big Finnish relief organizations, Suomen Huolto (Finland Relief) and the Mannerheim League for Child Welfare, have procured liberal donations of money from abroad and at home to support these building activities. Almost every rural county in Finland has received, or will receive, from the above-mentioned organizations pecuniary aid if the county agrees to build its health house according to the plans mentioned. The aid usually amounts to about 10 to 30 percent of the final expenditures. This financial help has stimulated the county to quick action. A few health houses in some of the poorest counties have been built entirely with funds from UNRRA, or the Mannerheim League, or the Finnish Government.

By the end of 1948 it is expected that 150 health houses will be either finished or in the process of being built. In addition, more than 250 counties have made their official decisions to build health houses, some of which it will be possible to build in 1949, and others at a later date. All depends upon the extent to which money donations and building materials will be available. Even though the health houses comprise only a small fraction of the building projects Finland has planned for the next few years, they will cost a total of about $11,000,000, which will heavily weigh down the balance of the already overburdened economic life of the counties. The above-mentioned relief organizations have already given to the counties over $2,000,000 for the building of the health houses. These organizations have as a goal the collection of an additional half million dollars at home and abroad for this purpose.

When the complete health-house building program finally has been finished, Finland can consider that she has ensured the inhabitants of her large but sparsely populated country's inhabitants as to their fundamental rights for health, so that every child and mother can get the health services they need, conveniently and close to home, as decreed by the law.

Reprints available in about 4 weeks

UNICEF STUDIES CHILDREN'S NEEDS IN THE FAR EAST

THOMAS PARRAN, M. D.

All that is being done, or contemplated, is but a drop in the bucket compared with the need.

I HAVE returned recently from a visit to India and Pakistan and a number of countries in South East Asia to see in what way the United Nations International Children's Emergency Fund could best aid the children there. Three million dollars had been allotted by the fund for this purpose. A separate allocation had been made for China, which was not in my itinerary. My problem was to see how such a limited amount could be made to count against the overwhelming needs of so many children in that part of the world.

This effort on their behalf was being made under the fund's mandate from the United Nations—to get help to those children who had suffered from the war, particularly in countries that had been victims of aggression. The war, which left millions of children destitute in Europe, left even more in a desperate plight in these other countries that had also been battlegrounds, in some instances for an even longer time.

The problem of getting help to them was and is far more complex than getting aid on a large scale to the children in the 12 European countries in which the fund is now operating. In Europe, despite all the devastation, there was a basic structure of child health, child welfare, and educational services, through which the fund could cooperate with the respective governments. Such was not the case in many, if not most of the countries in the Far East, and consequently the very complexity of the problem itself, coupled with its great size in relation to the fund's resources, tended to delay the initiation of a program. What could be done expeditiously was done, and the fund's effort during the first year of its operation was concentrated in Europe. Now, however, it is in a position to help children on the other side, even if only in a limited way. With Dr. C. K. Lakshmanan, director of the All India Institute of Hygiene and Public Health, Calcutta, I was sent to make the preliminary survey. Besides India and Pakistan, we visited Indonesia, Indochina, Siam, the Philippines, Burma, Hongkong, Singapore, and the Malayan Federation.

Specifically, we were sent to inform the various governments of the objectives and policies of the children's fund; to gather information on need for the type of program offered by the fund; to observe the condition of the children; to learn about health, feeding, and welfare programs already being carried on by the governments and by voluntary agencies; and, finally, to take the necessary steps for initiating agreements between the fund and the governments along the general lines of the fund's agreements with those countries to which it is already sending aid.

The population of the countries visited totals 550,000,000—a figure that gives perspective on what the fund will be able to do in relation to the need. Nevertheless, the fund's help can be made to count, perhaps not so much in meeting the immediate need as in building for the future. We were sent to find out how that small amount of money might best be used to improve the care and health of children, pregnant women, and nursing mothers.

Health conditions, we knew at the outset, have always been much below Western standards. What I, at least, did not know was how badly they had deteriorated during the war, particularly in the countries occupied by the Japanese. In some places, during the occupation, food shortages were severe and actual starvation was experienced. There was a total break-down of medical and scientific education, and for that matter, of practically the entire educational system. Medical supplies were generally lacking. Since the war and occupation political troubles have intensified the problem.

That problem varies greatly from country to country, but it has common elements. First, in most countries, is the shortage of food: There is not enough food in all the world to provide the people of these areas with what they need for their well-being. Chronic

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Excerpted from Children's Needs in the Far East. ***United Nations Bulletin, Oct. 1, 1948.***

malnutrition is the usual, not the unusual, condition. Hunger is the constant companion of most families. Conditions of near-starvation are not uncommon.

. . . . . .

In India and Pakistan the old problem of insufficient food is aggravated by the mass exchange of populations which followed partition. In Hongkong the problem is one of taking care of the large number of migrants from the surrounding area. When anything is done to improve living conditions in Hongkong, people inevitably move in from the surrounding countryside, and there can be no solution until conditions in these areas are also improved.

Milk, under such circumstances of malnutrition, is medicine. There is no possibility of bringing it in for any except the small proportion of infants and young children in hospitals and children's institutions, for whom it is needed if they are to survive. How precious it is is proved by the willingness of mothers to stand in line, literally for hours, in order to get a small can of condensed milk, or even some yeast powder. Lacking milk, the mothers in the rice-growing areas chew rice and then feed the babies with it just as a bird feeds its young.

Bound up with the shortage of food, and with the low standard of living which is the common lot, is the poor health of a large part of the population. In some areas more than one-third of all babies die in the first year, and fully one-half die before the age of 6. The Far East is disease-ravaged, and a good deal of the progress made before the war was lost in the general break-down of health services during and after it.

. . . . . .

In the midst of all this human suffering stand men and women with knowledge that only needs to be put to work. Everywhere, I was impressed with the high caliber of those who are trying to do something about the situation. Many of them have had the finest training the West has to offer, but too often cannot be used for lack of "tools."

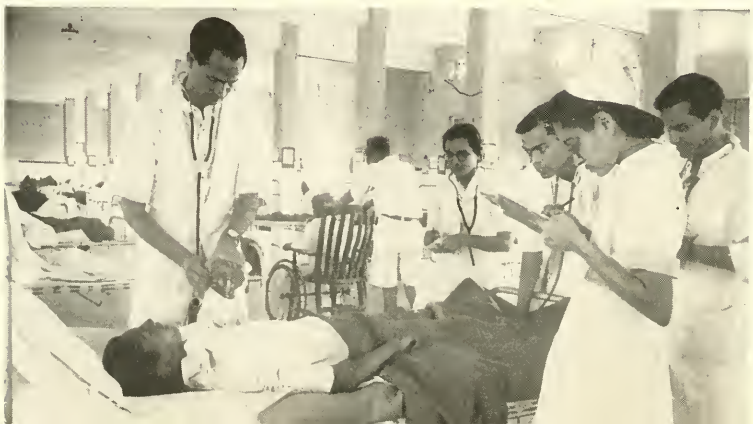
. . . . . .

All that is being done, or contemplated, is but a drop in the bucket in comparison to the need. That need is no less pressing because it is of such long standing. The suffering entailed and the human loss has been tolerated all too long, because what could be done seemed so small in relation to what needed to be done.

Such an attitude has no part in the thinking of the devoted public servants whom we met in that part of the world. They are working with enthusiasm, courage, and vision, and they are accomplishing much with their own limited resources. They can accomplish much more, I am sure, with the help which the people of many countries are offering them through the International Children's Emergency Fund.

Reprints of the complete report from which these excerpts are taken (published in the United Nations Bulletin October 1, 1948) may be obtained free upon request from the United Nations International Children's Emergency Fund, 405 East Forty-second Street, New York 17, N. Y., or 43 Avenue du Marechal Fayolle, Paris 16e, France, or UN Building, 106 Whang Poo Road, Shanghai, China.

Devoted public servants in the Far East are working with enthusiasm, vision, and courage.



• FOR YOUR BOOKSHELF

SERVICES TO CHILDREN IN INSTITUTIONS, by Cecelia McGovern, Ph. D. National Conference of Catholic Charities, Washington, D. C., 1948. 452 pp. $4.50.

Based on a study of some 40 institutions, this book, by the Child Welfare Consultant of the National Conference of Catholic Charities, considers institution programs and personnel in relation to the children themselves, rather than to physical set-up, plant management and equipment, or financing and budgeting.

It includes such subjects as the new role of children's institutions; treatment through group programs; house parents: specialists in the institutional program: education and recreation; religious and moral training; discipline; and in-service training. Social workers will find much familiar material, some of which, however, has not been generally accepted as yet by institutions. At the end of each chapter is a reading list.

The philosophy of group care as defined by Miss McGovern is a progressive one. She recognizes the need for small groups in institutions so that more individualization is possible for the child. Careful selection of children is emphasized, as well as the need to determine whether group care can be of constructive service to the individual child. The author points out that group care for young children, and especially for infants, is not desirable and may seriously damage the children, mentally, emotionally, and socially. She also stresses the importance of remembering that institutional placement should be temporary and that ties with families should be maintained.

An effort is made to clarify the roles of social worker, psychiatrist, teacher, chaplain, physician, nurse, and dietitian, as well as of the house parents.

Miss McGovern feels that failure to define carefully case-work functions in institutions has prevented wider acceptance of this service by institution superintendents. It is essential, she believes, that case workers for an institution should be on the institution staff instead of the staff of a child-placing agency. One case worker for every 50 children she considers the smallest number for efficient operation, with a case load as low as 35 active cases per worker if a real therapeutic job is expected.

There is little literature in the institutional field of child care, and this book will have considerable usefulness.

Throughout the book the material is related mainly to Catholic institutions, especially the chapter on religious and moral training. Consequently, the book will be particularly helpful for staff in Catholic institutions.

I. Evelyn Smith.

THE PIERRE THE PELICAN SERIES, by Loyd W. Rowland, Ph. D. Louisiana Society for Mental Health, 816 Hibernia Bank Building, New Orleans 12, La. (No price given.)

This series of 12 lively letters from "old Dr. Pelican," to be sent to parents once a month during the baby's first year, is one of the nicest things that have happened in parent education for a long time. The utter simplicity of the letters, their friendly informality, make them as attractive reading for professional people as for the parents for whom they were written. To put so many basic child-development and mental-hygiene principles into common, ordinary, understandable English is a rare feat.

Speaking in the role of old Dr. Pelican gives the author a chance to stand off and be objective about human creatures, to say many things which might have a little sting if said by a person instead of by a pelican.

Although the letters are especially concerned with the child's first year, parents will turn to them time and again during succeeding years for the implications they carry for later guidance of the child, and continued learning by parents. Such topics as reasoning with children, honesty, timidity, parents' feelings for one another, children who learn slowly, politeness, and money are taken up only briefly, but they are handled so skillfully that a parent reading them will probably remember their message longer than he would much more detailed advice.

Several States have already bought the series in quantity, for free distribution, and it is to be hoped that these letters will soon be even more widely known and used.

Marion L. Faegre

NURSING FOR THE POLIOMYELITIS PATIENT. Prepared and published by the Joint Orthopedic Nursing Advisory Service of the National Organization for Public Health Nursing and the National League of Nursing Education, 1790 Broadway, New York 19, N. Y. 1948. 88 pp.

The new handbook which was released in July by the Joint Orthopedic Nursing Advisory Service fills a much-felt need. It combines, and brings up to date, material formerly found in several pamphlets of the National Foundation for Infantile Paralysis: namely, "Nursing Care of Patients with Infantile Paralysis," "Nursing Care of the Patient in Respirator," and "A Guide for Nurses."

This pamphlet is particularly welcome at this time in the localities of increased incidence of poliomyelitis, as it provides reliable information in a convenient form for the use of the nursing personnel responsible for the care of these patients.

The list of references at the end of the publication is a helpful guide for additional material on the latest accepted methods of caring for poliomyelitis patients.

Florence L. Phenix

A limited quantity of each of the following items, reprinted by the Children's Bureau from sources outside the Bureau, is available for distribution. Single copies may be had without charge.

Case-Work Principles for Guiding the Worker in Contacts of Short Duration. By Fern Lowry. *Social Service Review*, June 1948.

Desirability of the Routine Use of Tetanus Toxoid. By Edward Press, M. D., M. P. H. *New England Journal of Medicine*, July 8, 1948.

Meeting the Needs of Orthopedic Children. By Florence Levy. *The Family*, May 1942.

The Middle-Aged Child. By Benjamin M. Spock, M. D. *Pennsylvania Medical Journal*, July 1947.

A Syllabus on Orthopedic Nursing. By Sarah N. Barnes, R. N. *American Journal of Nursing*, July 1948.

CALENDAR

Jan. 27–29—American Association of Schools of Social Work. Boston, Mass.

Jan. 31–Feb. 1—National Social Welfare Assembly. Annual meeting. New York, N. Y.

Feb. 2—National Social Hygiene Day. Further information from the American Social Hygiene Association, 1790 Broadway, New York 19, N. Y.

Feb. 3–4—National Commission on Children and Youth. Washington, D. C.

Feb. 4–5—Play Schools Association. Annual conference. New York, N. Y.

Feb. 6–12—Boy Scout Week. Thirty-ninth anniversary of founding of Boy Scouts of America. Further information from Boy Scouts of America, 2 Park Avenue, New York 16, N. Y.

Feb. 6–13—Negro History Week. Further information from the Association for the Study of Negro Life and History, Inc., 1538 Ninth Street NW., Washington 1, D. C.

Feb. 7—National Children's Dental Health Day. First observance. Further information from the Council on Dental Health, American Dental Association, 222 East Superior Street, Chicago 11, Ill.

Feb. 7–10—Nation-wide Conference and Exposition. Auspices of the New York State Cerebral Palsy Association, Inc., New York, N. Y.

Regional conferences, Child Welfare League of America:

Feb. 10–12—Southern Regional Conference. Montgomery, Ala.

Mar. 17–19—Ohio Valley Regional Conference. Cincinnati, Ohio.

April 7–9—Eastern Regional Conference. Atlantic City, N. J.

May 1–4—Midwest Regional Conference. Chicago, Ill.

June 6–7—New England Regional Conference. Portsmouth, N. H.

Area conferences, National Child Welfare Division, American Legion:

Feb. 11–12—Area B—Delaware, District of Columbia, Maryland, New Jersey, New York, Pennsylvania, Puerto Rico, Virginia, and West Virginia. Baltimore, Md.

Mar. 4–5—Area A—Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, and Vermont. Boston, Mass.

Mar. 11–12—Area C—Alabama, Arkansas, Florida, Georgia, Kentucky, Louisiana, Mississippi, North Carolina, Oklahoma, Panama, South Carolina, Tennessee, and Texas. Jackson, Miss.

Feb. 20–27—Brotherhood Week. Twentieth anniversary of the founding of the National Conference of Christians and Jews. Further information from the National Conference of Christians and Jews, Inc., 381 Fourth Avenue, New York 16, N. Y.

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FOR EVERY CHILD THE RIGHT TO SCHOOLING

Any employment that deprives children of the education to which every child is entitled disturbs the public conscience. Today employment of children in agriculture is a matter of wide public concern, particularly where it competes seriously with children's attendance at school.

For many years most of the children who stayed out of school to work in agriculture were helping their parents on the home farm. Teachers were well aware that absences from school for farm work retarded the child's progress, and that too much absence frequently meant that a child dropped back in his studies. Nevertheless, as long as most of the employment was on the home farm, or under comparable conditions on neighbors' farms, the public conscience was not much disturbed about it.

But farming has changed. No longer are most of the children who are hired on farms helping the farmer with that wide variety of interesting outdoor activities about which some oldsters brought up in rural areas have nostalgic memories. Very prevalent and probably more characteristic of employment of children in agriculture today is the mass production of specialized crops in which hundreds of thousands of children are hired by farm operators, to whom a child is only one more seasonal worker. Hired child workers of this generation are likely to be confronted with acres and acres of beans or cotton, tomatoes or potatoes. Farm work of this type involves endless, repetitive, dull, monotonous tasks.

People who take the trouble to visit these mass-production agricultural areas are shocked to see young children doing such hard work for long hours. They are more shocked when they realize that such work is depriving many of the children of the schooling which is a prerequisite to intelligent citizenship.

A national step in the direction of preventing competition between agricultural employment and schooling for children under 16 was made in 1938 when Congress passed the Fair Labor Standards Act.

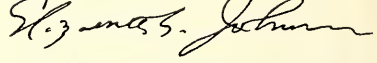
This law makes illegal the employment of children in agriculture while they are required by State law to be in school. In effect, the employment of children for such jobs is thus made illegal during school hours in places where school attendance is required of practically all children under 16. But their employment in agriculture during school hours may be legal in places where State school-attendance requirements are not so strong.

The article, Fair Labor Standards Act Seeks To Protect Children in Agricultural Jobs, appearing elsewhere in this issue, outlines the provisions of the act as they affect the employment of children in agriculture, describes what has been done to enforce these provisions, and draws conclusions in regard to their limitations.

Loss of schooling and comparatively low educational attainment, more prevalent in rural than in urban areas, tend to perpetuate for agricultural workers their relatively low-earning capacity and, for many, their migratory status, and the resulting housing and health problems.

An essential measure for improving the conditions that handicap rural child workers is better protection from child labor that interferes with schooling. This is one of several fronts on which progress must be made if rural children, and particularly those whose parents also are agricultural laborers, are to have the education, health, and opportunity for satisfactory community life that we believe all children should have. Specifically this means legislation outlawing all employment of children under 16 during the hours that schools are in session.

We are a rich enough nation to afford to have our vegetables, fruits, and cotton picked by workers earning a living wage instead of by children deprived of their opportunity to go to school.



Director, Child Labor Branch, Wage and Hour and Public Contracts Divisions, U. S. Department of Labor.

VOL. 13, No. 7 JANUARY 1949

the CHILD

published monthly by the
Division of Reports
CHILDREN'S BUREAU
Managing Editor Sarah L. Doran
Art Editor Philip Bonn

FEDERAL SECURITY AGENCY
Oscar R. Ewing, Administrator

SOCIAL SECURITY ADMINISTRATION
Arthur J. Altmeyer, Commissioner

CHILDREN'S BUREAU
Katharine F. Lenroot, Chief

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Publication of THE CHILD, monthly bulletin, was authorized by the Bureau of the Budget, May 12, 1936, to meet the needs of agencies working with or for children. The Children's Bureau does not necessarily assume responsibility for the statements or opinions of contributors not connected with the Bureau. THE CHILD is sent free, on request, to public officials and libraries. For others, the subscription price is $1 a year. Single copies, 10 cents. Send remittance to the Superintendent of Documents, Government Printing Office, Washington 25, D. C.

U. S. GOVERNMENT PRINTING OFFICE: 1949

FEBRUARY • 1949

the CHILD

WORKSHOPS OF WONDER

Children's Museums Are Creative Laboratories of Leisure

KATHERINE GLOVER *Information Consultant,*
Preparatory Activities, Midcentury White House Conference on Children, Children's Bureau

SOME of us can recall among our most exciting childhood memories the rainy Sunday afternoons when Aunt Patty unlocked the corner cabinet in the parlor and allowed us to look at and touch the treasures behind its glass doors.

Through the magic of the stereoscope we entered a different world, glimpsed the beauty of snow-peaked Alps, of Niagara Falls, and the California redwoods.

We smelled the spicy odor of rose leaves in the gold and crimson Venetian glass jar, and fingering the bit of petrified wood we conjured up a petrified forest.

A world of wonders opened with the unlocking of the cabinet door. Today, children in many places have a door to an infinitely greater variety of wonders, through which they can walk without waiting for Aunt Patty to turn the key—the door to the children's museum.

Museums specially for children are comparatively new. They have taken their place in the modern scene without much publicity. They vary considerably in size, plan of organization, scope, and character; but in all cases they offer opportunities for children to explore, make the past live again, bring the strange, the faraway, and the unknown within the range of their imaginations and vision.

Above all, children's museums belong especially to children. Cases are made to their height, legends written for their understanding, exhibits planned and displayed to answer their whys of curiosity. They are places of movement and life. With the pressing of a button trains move, wheels turn, lights flash, and an inanimate world comes alive.

Museums broaden lives

The best museums go far beyond the purpose of educational visual aids, although this is an important contribution. In the great variety of clubs and games, the creative-music, drama, craft, and science groups, they offer to children a gamut of interests that no other one place provides.

The oldest children's museum in the world is the Brooklyn Children's Museum, started in 1899. The second oldest, one of the best and most complete, is the Boston Children's Museum, organized 30 years ago.

The Saturday I spent visiting the Children's Museum in Boston I wished for Alice in Wonderland's magic bottle. To view any children's museum rightly one should shrink to the size of an 8- or 10-year-old and see things through a child's eyes.

Outside, the day was gray and damp; inside, in contrast, was life and color, and the wonder and happiness reflected on children's faces. They darted like beetles from case to case, some pausing in silent delight, others in a twitter of excitement. It was late fall, and a specially arranged exhibit showing how the animals prepare for winter held fascinated groups. They could see the underground cache of nuts which the squirrels and chipmunks had stored away, the changing color of the squirrels' fur, and the flocks of birds southward bound.

An exhibit of dolls representing the people of all the countries in the United Nations made the UN more real to the

rapt group who gathered about the exhibit. One small, dark-eyed boy said, "My father was born in Italy." A little girl with blond pigtails spoke up proudly, "My grandmother came from Norway and she has a costume just like the one the doll has on." In exhibits all through the museum children touched the life of countries hitherto known to many of them only through words in textbooks.

A small mob crowded the live-animal room, always a favorite spot. Snakes, lizards, baby alligators, polliwogs and frogs, turtles, and squirrels eternally delight the museum devotees. Some of them have themselves contributed to the collections many specimens gathered in trips to nearby woods or in their travels.

In the habitat groups of stuffed animals "Molly," the baby elephant, has always a group of loving admirers about her case. In life, Molly had been loved by many of the fathers and mothers of today's museum patrons, whose nickels and dimes had helped to bring her from India. Molly, however, had not long survived the transition from the jungles of India to the Boston zoo. On her demise she was tenderly preserved in the Children's Museum.

Tradition carried on

From one part of the museum came the melodious sound of musical bells. Under the guidance of Mrs. Elsie M. Boyle, director of the museum, I found in one of the clubrooms a group of six or seven boys and girls practicing bell-ringing with a series of old English hand bells. Some years ago an elderly resident of Boston, born in England, brought eight old English hand bells to the museum and trained a member of the staff to play them. The skill was passed on. In consequence, here among these young patrons of the Boston Children's Museum an almost vanishing art is being preserved. A graduate group of bell-ringers is much in demand for public appearances in and around Boston.

Never a dull moment

The variety of activities going on in the museum was great, with something to catch the interest of any age group and all types of youngsters.

In an annex to the main building we found some of the youngest patrons hunched and sprawled on the floor. Under their crayons bright red trains, purple airplanes, green and blue objects bearing faint resemblance to ships and busses and streetcars took shape. The young artists were presenting their favorite means of going places. The result, if not art, was at least a free and vivid picture of what was in the children's minds.

The afternoon brought flocks of children for movies or a story hour. Some of the youngsters, moving from one activity to another, spend the whole day in the museum, bringing their lunches with them. Many of them wander about on their own; others are accompanied by a member of the staff, who helps to answer questions, expand or explain the legends on the exhibits.

The Boston Children's Museum is located at Jamaica Plain in a spacious building, once a private residence, with pleasant grounds surrounding it. The former stables have been converted into an annex with a fine, newly constructed auditorium. Building and grounds were a memorial gift to the Children's Museum Corporation.

The museum is on the edge of a thickly populated section, within walking distance for many children, including those of less privileged families, and within easy-transportation range of children from all parts of Boston and nearby communities. Just beyond the museum is a lake, with woods on the other side. This offers important adjuncts to the museum, with opportunities for jaunts and explorations. In summer, when members of the Jaunters Club make daily trips, they come back with trophies to add to the museum collections. Polliwogs are scooped from the lake, butterflies and turtles and cocoons collected in the woods.

Most children's museums, where they are well planned and adequately staffed, as in Boston, spread their in-

The programs centered in children's museums, where such exist, offer many suggestions for ways to encourage creative activities for children and young people, deepen their cultural roots, and enrich the quality of life. While not every town may be able to have a children's museum, many of the same kinds of interests that museums encourage can be carried out under other auspices—by community centers, recreation departments, schools, clubs, churches, informal neighborhood groups, even families.

There are great gains to be had from richer use of children's and youth's leisure time, with opportunities to create, and to do things together—music, art, and plays; crafts; pageants. Not only is this a way to prevent many of the ills of modern life and lay sound foundations for social and mental health, but it is an antidote for much of the ready-made entertainment of radio, movies, and comics.

Widespread encouragement to the creative use of leisure time for young people throughout the country would fit into the preparatory work for the 1950 White House Conference, where groups of citizens in States and communities are looking anew at children, appraising the influences and services which are molding their lives, and determining constructive goals to work toward.

fluence far beyond their own boundaries. They serve the schools, clubs, and churches, supplementing and extending their programs. The children's museum in many instances serves the visual-aid function of the school program. Special exhibits are arranged in cooperation with classroom work and scheduled to fit into the school program. Exhibits are also lent to the schools. Certain permanent basic exhibits give realistic meaning to history, geography, and, especially, to the social studies.

It would be difficult to compress into one article the full range of interest of any one of the well-established children's museums, and describing a few does not tell the story of what others are doing. Most of the museums have certain features in common, but each has distinguishing differences or accents of interest.

The Brooklyn Children's Museum has been an institution in the lives of more than one generation, not alone of Brooklyn children, but of children from New York and Long Island. Its loan exhibits have been sent on request to many parts of the country.

Has its own building

In the near future it will be housed in a building designed specially for its own purposes, and so will be the only such children's museum so far in this country.

The plans are in readiness, and building will begin as soon as municipal budgetary approval is granted. This will inaugurate a new era in children's museums, just as the Brooklyn Children's Museum at the outset paved the way for a new movement.

At present the museum occupies two neighboring buildings, converted residences of an earlier era, with large grounds around each of the buildings. The Brooklyn Children's Museum has been, since its beginning, a branch of the Brooklyn Institute of Arts and Sciences; and while it functioned always as a separate children's museum, it was operated as a subsidiary of the larger institute. In 1948, however, it achieved the dignity of independent identity, with its own governing board, operating as a full-fledged unit in the Brooklyn municipal system of museums, with its own governing committee.

Starting its history with one case of birds and one of minerals and shells, which could be arranged in a single day, the Brooklyn Children's Museum now has an amazing variety of exhibits. Its dioramas, telling stories in figures and objects in realistic settings, delight the eye and the imagination. They are genuine works of art as well as authentic presentations which bring chapters from the past vividly alive to children.

A major part of the museum program is cooperation with the schools. Any weekday sees a succession of school classes streaming in and out of the buildings.

Part of the museum is given over to clubrooms, where a variety of clubs come and go in after-school hours, on Saturdays, and during vacations. Music groups sometimes make their own simple instruments. The leader of a camera group has taught children who cannot afford cameras of their own to make them out of boxes. There are movies every afternoon and on Saturdays. The museum owns a large library of films and rents and borrows others.

The Brooklyn Children's Museum is organized in five divisions, which cover its varied fields of activity: Education, science, social studies, natural history, and library. Located in a great metropolitan center, it offers to city-bred, often slum-dwelling children a magic carpet that transports them to faraway places and novel experiences.

Miss Anna Billings Gallup, an early director of the Brooklyn Children's Museum, said she developed the exhibits by "following the child around" and thus discovered how children look at things and what they are interested in. Whatever the reason for it, Brooklyn's museum is peculiarly child-centered.

In free hours boys and girls do their own collecting of specimens for the children's museum.

Schools and museums work together

In a number of places the children's museums have developed in conjunction with the schools and operate under boards of education. This is true of the children's museums of Detroit, Mich.; Indianapolis, Ind.; Hartford, Conn.; Cambridge, Mass.; and Duluth, Minn. The San Francisco Children's Museum operates as a part of the city's department of recreation and strongly emphasizes the leisure-time activities of children.

The Junior Museum in Newark, N. J., offers a program which turns the chil-

dren's wing of the beautiful Newark Museum into a beehive of activities for children of all ages. Vacation or after-school hours may find club groups doing pottery or clay modeling, studying specimens under the microscope, or learning the rudiments of taxidermy through stuffing and mounting birds or small animals.

The Newark Junior Museum has members who pay a small fee. Any child may enjoy the museum, but members have certain special privileges. Since the museum is one of the oldest, established in 1916, it has many "graduates," pursuing life vocations which began in their club interests and hobbies at the museum.

Recently one issue of the publication, Drums, which members of the Junior Museum get out, was devoted to contributions by these graduates. One of them wrote: "While I was a member I was busy enjoying the activities in themselves without being aware of all the knowledge I was absorbing. It was a kind of learning, different from that obtained by reading books or attending school."

That perhaps is the distinguishing characteristic of most children's museums, the learning that is self-sought and comes through pure delight in the subject.

The children of Indianapolis actually own and direct their museum. The original bylaws which created it provided for a junior board of directors, the members to be appointed by the schools in each district. A teacher acts as sponsor to the board. These junior directors have developed a number of extremely interesting projects.

This self-governing and self-owning principle obtains in many of the children's museums, and is perhaps one of the chief reasons they so delight and hold children of all ages. Many museums welcome the contributions of the youngsters. One small boy in Boston who lives in a densely populated section has a passion for snakes. He manages somehow to find them under rocks in occasional vacant lots and comes to the museum with his pockets full of small reptiles to add to the snake collection.

The Boston Museum also has its junior museum council, a group of boys and girls who have become so interested in the behind-the-scenes workings of a museum that they are creating a museum of their own in one of the rooms of the building, painting their own cases, gathering and arranging collections.

Children's painting may not be art, but it gives a vivid picture of what is in young minds.

Detroit Children's Museum, which is one of the most extensive in range of exhibits, is an integral part of the city's schools. Children come to the museum for part of their instruction, and the museum goes to the schools with a wide selection of exhibits for science, social studies, and other subjects.

In their own backyards

Learning becomes an adventure through the imaginative exhibits which the museum presents for Detroit children. An archeological exhibit, for instance, is built around a story called "Mr. Bones." The archeologist is presented as the Sherlock Holmes of history, who must piece together the past from fragmentary clues buried in the earth. And archeology is brought into the children's own backyards by showing what a "dig" in Michigan brought to light. The story of how the archeological Sherlock Holmes went about his work is shown step by step, and what he found is revealed in objects and exhibits and explained on labels.

The Detroit Children's Museum has done a great deal of research in the field of docentry, or museum teaching. It has made studies to determine how abstract ideas and remote subjects can be translated into terms of the child's experience: for instance, how such a subject as "power" can be made to speak to the child through things familiar in his everyday experience.

Much attention has been given by the museum staff to the technique of handling classes and of helping classroom teachers make use of the museum. Loan exhibits are infinitely varied. Citizenship may be brought home to children through an exhibit on "Look at Your Neighborhood"; democratic human relations pointed up through an exhibit on "The Negro in American Life," or "Music, the Universal Language"; arithmetic brightened by an exhibit on "Purchasing Power," showing the romance of money. And so on and so on, new windows opening on old, dry subjects.

The Hartford (Conn.) Children's Museum belongs very specially to the people of Hartford; particularly, of course, to the children. Out of 400,000 metropolitan and suburban population, 100,000 visitors a year are attracted to the museum. In its close cooperation

with the schools and its club programs this museum has much in common with others, but it has several features that mark a difference.

Its live-animal department is one. This has been developed with the specific idea of presenting a living exhibit of the principles of heredity and sex education. Animals with a short gestation period, such as guinea pigs, hamsters, white mice, and white rats are exhibited. While no formal sex education is attempted, voluntary questions of the children are carefully answered and work with adolescents is skillfully carried on. In cooperation with the Glastonbury chapter of the Future Farmers of America, an exhibit of farm animals has been started, which gives city children an opportunity to see lambs, goats, calves, turkeys, and chickens at close range.

A Children's Museum of the Air carries the museum by radio to many listeners, in a delightful Saturday morning program in which the Museum Lady, the announcer, and two children from different schools of the city tell a story dramatically, largely through questions and answers, on a subject which may vary from the beginnings of written language with the Chaldees to a chat about bird migrations.

For little ones too

Another unusual venture of the Hartford Children's Museum is its nursery school, with a preschool program for 3- to 5-year-olds, who usually are considered too young to share in the delights of a museum. This is held 2 days a week under the direction of a trained kindergartner, with a director of group singing and a museum-staff member who conducts finger painting.

The museum also is developing a series of booklets designed for young readers, which will cover a wide range of subjects: Three on shells, and others on such topics as "Fossils of New England," "Connecticut Indians," and similar subjects. The booklets are in large manuscript printing for easy reading, of a size to go in a small boy's pocket and with blanks left to fill in with objects found by said small boy, or girl. Cost, 25 cents a copy.

The opening of a new exhibit at the Denver Children's Museum is an exciting event. So are its Saturday-afternoon programs for museum members and the special events staged at holiday seasons. The museum is a center for movies, puppet shows, dance programs, music and art demonstrations.

Art is a major accent, and the workshops for young craftsmen are among the most important features of the children's museum. Members of the Young American Craftsmen experiment with paint, clay, pâpier maché, wood carving, puppetry, basketry, soap carving, and mural painting. They also enjoy conducted gallery tours through the art museum, and from time to time have the experience of watching living artists at work and learning from them something of their technique.

Membership fees are 10 cents for junior members, first to third grade, and 25 cents for seniors, fourth grade up. It will be surprising if a future roster of American artists does not list among its members some who found their early inspiration in the Denver Children's Museum workshop.

Pasadena (Calif.) Junior Museum also has a children's workshop with the special purpose of encouraging creative expression in the everyday life of children. The summer workshop runs for 8 weeks during the vacation period. It is planned with the assistance of the public schools and is under the supervision of a professional artist. The young artists work in a variety of media, including water color, pastel, poster paint, pen and pencil, charcoal, wood, and clay.

A children's theater is another important activity of the museum. The children's museum is sponsored by the Pasadena Junior League and, except for the professional artist who supervises the workshop, it is operated entirely by volunteers. Yearly exhibitions of the children's work are held. A feature of this year's exhibitions will be an international showing of children's paintings and drawings gathered from all parts of the world. The junior museum is housed in the Pasadena Art Gallery.

Also in California, a somewhat similar project, sponsored by the local Junior League, is the Junior Art League in San Diego. Because of limited facilities in the Fine Arts Gallery of San Diego the League restricts activities to children of the fifth and sixth grades, considered an appropriate age since they are old enough to get the full value of the program and young enough not to be involved in junior high school activities.

Making better citizens

The purpose of the program, which includes an art workshop, gallery tours, exhibits, and opportunities to observe artists at work, is to make better citizens by giving children an appreciation of beauty, developing their cultural backgrounds, and providing opportunities for creative expression.

A number of fine programs for children are carried out in the larger city museums. Some years ago the Metropolitan Museum of Art in New York City swept out plaster casts and other objects from five of its first-floor galleries and converted the space into a junior museum for children's activities, with special facilities and exhibits. This is part of the museum's educational services, and programs are worked out in cooperation with the city's schools.

Junior study looks to future

A junior art-reference library is one of the important features of the children's section of the museum. The junior-museum program is not confined to the special section of the Metropolitan but includes an introduction to the treasures of this rich treasure house of art objects.

All this is a far cry from the days not so very long ago when children under 16 were forbidden to enter some of the most respected museums of the country.

George Washington Stevens, creator of the Toledo Art Museum, was known as the Pied Piper of Toledo because of the eager youngsters who flocked to the museum to share in the program of creative music he instituted. This modern Pied Piper's creed was: "No city is great unless it rests the eye, feeds the intellect, and leads its people out of the bondage of the commonplace."

So large is the stream of youngsters who gaily wend their way to the museum on Saturday mornings that traffic in the surrounding streets is almost tied up. The young musicians have their own orchestras, make their own instru-

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SO THAT CHILDREN MAY ENJOY BETTER MEALS

Consultant Service Given to Maryland Institutions

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JANE HARTMAN *Consultant Dietitian, Maryland State Department of Health, Baltimore*

MUST children in institutions be served "institutional" meals? Or is it possible to keep within in the budget and still give the children food that is not only nutritious, but also appetizing?

Most institution staffs want to feed their children properly, and they do their best. The workers in charge are gratified to see the good health and spirits of children who are eating well and enjoying their meals.

But to supply good meals to children in an institution is a difficult task, however conscientious and intelligent the staff may be.

Right foods must be chosen

If the children's health is to be safeguarded, they must eat enough of the foods that include the essential nutrients. And some one on the staff must know how to select these foods.

Again, an institution must stay within its budget, and some one must know how to purchase foods economically, or to requisition them skillfully.

Then, the food must be stored and cared for. Food is precious, and much of it is perishable.

And, aside from the food on the table there is the appearance of the dining room, which may affect children in an institution even more than it does other children. (The emotional atmosphere at meals is, of course, tremendously important, but we leave that subject to workers in the field of mental health.)

Next comes planning the meals, and then supervising the preparation and serving of them. These steps are very important to an institution that wishes to have its children eat well.

All children, of course, should have the opportunity to eat a variety of foods, properly prepared, and served in attractive forms. But eye appeal in meals is especially important for children in an institution, for these children are often poor eaters.

An institution head may purchase good food, and may have no idea how badly it is cooked and how uninterestingly served to the children. Recently one of us saw a meal served to children at a camp. The menu read: Chicken and noodles, cabbage, potatoes, bread and milk, and vanilla pudding. On paper these dishes seemed pallid, but no worse. But on the table the meal was not only colorless, but sloppy. The cabbage had been boiled till it was a pale tan color, and watery. The chicken was shredded; it was about the same color as the cabbage, and also watery. The other white foods completed an unappetizing meal. No wonder some of the children refused to eat and a few cried throughout the mealtime.

Costs affected by various factors

Going back to the budget, we all know that the amount of money that an institution can spend has a great deal to do with the kinds and amounts of food that it provides for the children. But we know also that an institution with good financial resources may fail to give the children the food they need, while another one manages to serve good meals on a much smaller budget. Methods of buying, serving, and handling foods, including use of leftovers, seriously affect costs. Sometimes an institution that seems to have a large enough appropriation for food serves inadequate meals because such things as cleaning supplies are charged to food costs.

Then there are the institutions that can afford to serve plenty of good food, and do so, but pay little attention to the appearance of the food or to the children's likes and dislikes. And in this connection we might add that an important qualification for anyone who has to do with child feeding is an interest in children. This is one of the reasons that some institutions feed children successfully in spite of adverse conditions.

But even these institutions, and certainly the less successful ones, may sometimes need professional help in their job of child feeding. Many needed this help especially when World War II brought on food shortages and rationing, as well as loss of workers.

Realizing that these war conditions must be detrimental to the feeding of children in some institutions, the Maryland Dietetic Association in 1942 offered free consultation to children's institutions in the State that did not have a dietitian. The members of the association, professional dietitians employed regularly in hospitals, restaurants, school lunch rooms, and so forth, gave this consultant service on their own time, as a contribution to the war effort.

During the first year few institutions replied to the offer, and most of these wanted help chiefly with rationing problems. It was evident that most of the institutions that were without dietitians felt that they did not need professional help in feeding the children. This did not always mean that they were satisfied with their feeding programs. It may have meant in some cases that they were doing the best they could under their circumstances. Many, however, undoubtedly failed to realize that there were any problems other than rationing.

But sometimes, when a consultant was working out a solution of the rationing problem with an institution staff mem-

ber, this led to discussion of nutrition and food service. Then would come a request for help with some phase of the child-feeding problem. And after a while the whole problem would be discussed.

As time went on, more and more institutions, including schools for delinquent children, homes for unmarried mothers, group foster homes, and others, began to ask for consultant service. And by the end of the war the association was receiving more requests than the members could fulfill.

When an institution had accepted the offer of help, the consultant that went to visit it would be able to give considerable assistance even at the first visit. She could, for example, point out satisfactory, and easily obtained, substitutes for rationed foods. And she could help the institution to make the best possible use of its allotment of such foods.

Some small institutions were found to be buying food at retail because none of the staff was familiar with wholesale buying. In such cases the consultant gave advice about ways of getting in touch with wholesale dealers and about economically sized packages and units of purchase.

Another consultant service was to demonstrate how institution menus could be adjusted so that the foods would be more adequate and less costly. For example, an institution might be spending too much for meats and too little for milk, vegetables, and fruits.

Some institution workers did not realize that it is possible to stretch the sum budgeted for milk and eggs by buying evaporated milk, dried skim milk, and egg powder. Consultants were able to show institution workers how to prepare these economical foods appetizingly.

In many institutions a consultant found that the staff had been reduced by wartime conditions, and that the remaining workers were having a hard time. In some of these the consultant was able to suggest better methods of organizing the work so that the burden was lessened and the workers did a better job.

Again and again a superintendent or a board member would ask, "What should it cost to feed the children properly?"

So that we could give an answer to this question, the authors of this article—both of us were consultants—worked out a method of estimating the weekly cost of an adequate diet for children in institutions.

We based our figures on a plan prepared by the United States Department of Agriculture, Bureau of Human Nutrition and Home Economics.

The plan gave kinds and quantities of foods in an adequate diet for a week, under both a low-cost and a moderate-cost plan. The diets fulfill the standards of adequacy recommended by the National Research Council, and the costs are based on studies of the eating habits of thousands of families of all income groups.

Seventy-three familiar foods were listed in the plan, divided into 11 groups. A chart showed what amounts of the foods in each group should be purchased weekly to supply adequate food for children of different ages.

Amounts were given separately for low-cost and for moderate-cost diets. We selected the moderate-cost plan, because it provides more variety than the low-cost one, and variety of foods is important in getting people in institutions to eat the foods they need, whether they are children or adults.

The amounts of foods suggested in the chart were based on purchases in family-size packages. And so, with the help of a Bureau food economist, we adjusted the plan so that we could figure costs from institutional-size packages. We then calculated the wholesale cost of a week's food, and the total gave us the answer that the institutions were asking for.

This method of estimating the cost of adequate food for children, on the moderate-cost plan, was tested at a boys' summer camp. The quantities of the various foods served during a week at the camp were compared with those specified by the Bureau of Human Nutrition and Home Economics, and the camp diets were found to meet the Bureau standards for adequacy in every food group and to exceed them in some groups. Then we compared the cost estimated for a week's food with the actual cost, and the actual cost per child proved to be only 7 cents a week greater than the amount we had estimated.

In a tuberculosis sanatorium, these children are eating what is good for them and enjoying it.

When a consultant visited an institution, usually the superintendent would ask her to analyze the menus to see whether the children were getting the right food. The consultant knew, of course, that such analysis by itself was not enough to show whether the diets were adequate. She would analyze the menus, as requested, but would also explain to the superintendent that she would need to study a record of all the foods served during a given period, say a week. This record did not take account of food wasted, but otherwise it gave a fair picture of the types and amounts of food the children were receiving.

From the record the consultant classified the food served, according to the 11 groups mentioned previously in connection with calculating costs. She then compared the amount of food in each group that was served to the children during the week with the amount specified in the plan as needed by children of their age.

The superintendent of one institution that had been doing an excellent feeding job without trained personnel expressed her gratification when the consultant gave her a favorable report on the adequacy of the children's diet.

"We have tried to feed the children properly," she said, "but we have always wondered whether they were getting the right amounts of all the various proteins, minerals, and vitamins. Now we know for sure, and we know how to check on ourselves in the future."

To calculate feeding costs

A simple method of cost accounting was requested by many institutions. One method suggested by the consultants is as follows:

Give a separate page to each group of foods, such as dairy products, for a specified week.

In the first column list alphabetically all the foods in the group, such as Butter; Cheese, American; Cheese, cream; Cheese, cottage; Eggs; Milk, canned; Milk, fresh; and Oleomargarine.

The next column will be headed, "Amount on hand from past," and the next one, "Unit cost." Then comes "Amount received during week," and then, "Unit cost." Next is "Total on hand this week." The following seven columns are for the days of the week, so that the amount of each food used every day can be written in. The last two columns are headed, "Total amount used in week" and "Total cost for week."

To get the total cost of the dairy products used in the week, add the figures in the last column.

When the costs of all the groups are added together the total is the cost of the week's food.

An educational program needed

The amount of food left on the plates, and other evidence, suggested to the consultants that there was great need for an educational program in nutrition, both for the children receiving care and for the staff members. In one home for unmarried mothers many of the girls had been so used to a poor diet in their own homes that they did not care for the balanced, nutritious meals that the home provided, with milk, and a variety of vegetables and fruits.

The consultant asked the doctor who was in charge of the girls' health to join with the staff in trying to change their food habits. She also referred the staff to sources of posters, pamphlets, motion pictures, and film strips that present attractively the advantages of eating enough of the right kinds of food.

The consultant service of the Maryland Dietetic Association, which was set up entirely as a wartime service, was discontinued according to plan after the war ended. But by the time the work ceased, many institutions had begun to realize that this kind of help is needed for a good feeding program. And so many nursery schools, hospitals, homes for the aged, and so forth, called on the nutritionist in the State department of health for dietary consultation that in less than a year after VJ-day the department appointed a consultant dietitian on its staff, full time, to give regular service to State institutions.

Regular weighing is a valuable part of the nutrition program at this summer camp for boys.

Under the supervision of the health department's consultant dietitian, educational programs have been established in two State training schools for delinquent children and in all the State's tuberculosis sanitaria. Through motion pictures, posters, and talks, efforts are made to correct the poor eating habits of the children and others in these institutions.

In the sanatoria this educational program also includes use of a pamphlet, Eat Your Way to Health, which

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DOCTOR SHOULD BE MOTHER'S GUIDE, PHILOSOPHER, AND FRIEND

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IN ALL studies of the psychological development of the child, it has been repeatedly pointed out that the parents, and particularly the mother, play the dominant role in the evolution of his emotions, of his personality, his adjustment to his social environment; indeed, even of his intelligence. The nervous mother may be expected to have a nervous child. Insecurity and emotional imbalance in the parents are reflected in the child.

And so it follows (1) that if the mental health of the child is our concern, we must focus our attention on the mother and (2) that the most effective way to prevent personality disturbances in the child is to give him well-adjusted parents.

This, I grant you, is a big order and one that presents to the pediatrician a problem that often seems beyond his control to solve.

We must, however, accept it as our concern, analyze the way in which we are actually attacking it, and evaluate our approach in order to determine whether or not the part we play is productive of the best possible results.

It is with this thought in mind that I wish to call to your attention some of the commonly accepted patterns of relationships between the physician and the mother.

Let us assume that we are considering the case of young parents faced with the responsibilities of their first baby. They have, to a greater or less degree, shaken off the domination of their own parents and taken their place as adults with a home of their own, but the young mother feels much uncertainty and ignorance in relation to the baby. This new job is one for which she has had little preparation.

Perhaps, in spite of her feelings of uncertainty, she is determined not to lean on her own mother, from whom she has managed to liberate herself. Nevertheless, her intellectual desire for independence is in conflict with her emotional longing for support and protection in this new situation.

Mother needs self-reliance

If she is to be a mother that her child can trust, she must learn to trust herself; but her many fears, often increased by stories she has heard and articles she has read, give her no freedom to use her instinctive feelings of protectiveness, of "mothering." Instead, she often tries to bury these feelings and to follow her intellect rather than her instinct.

And how does the medical profession help her to meet her problem?

A fairly high percentage of mothers-to-be receive excellent medical care during pregnancy, but they seldom are prepared for the task of motherhood in any way that concerns itself with their feelings about it. They are not given much opportunity to discuss even the practical aspects, such as where to put the baby's crib—in the cold bedroom where it can be isolated or in the hot living room in which gather family and friends. Or whether to hire a practical nurse to care for the baby for a few weeks, or a houseworker who can cook and clean. And how much it will cost to keep the baby after he arrives.

These are all things that may influence the environment of the first months of a baby's life, but even more important are the emotional problems that the young mother may be trying to solve alone or with very inadequate help.

Perhaps she feels resentment of pregnancy, or fear of childbirth, or anxiety lest a baby will interfere with the father's rest and comfort and so be a source of trouble between them.

"Suppose the baby isn't perfect" is a question that often haunts the mother. Even "Suppose I find that I don't love it." Or "Suppose it's a girl, when my husband has set his heart on a boy."

The doctor who allows time for the discussion of such worries may not be able to wipe them out, but the very act of putting them into words is often healing when the listener accepts them seriously, and, without scorn or ridicule, helps the mother to face her fears in the light of reality.

Perhaps I am placing too much emphasis on a situation which is the business of the obstetrician rather than of the pediatrician. But one so often meets a young mother who brings her baby for infant care with these very fears unresolved, that this phase of the problem of preparing a well-adjusted mother to care for her baby cannot be ignored.

I must also say a word about the separation of mother and baby during the hospital stay. Certainly there are few who would argue that this is a natural state of affairs. Although not many

The doctor should be a source of strength and reassurance, a friend with whom a mother can talk over her problems and whose greater experience and objectiveness will help her see these problems in their proper light. He is the guardian of her child's health and well-being.

of us can achieve the rooming-in arrangement that has been begun at New Haven, we pediatricians can and should urge that the separation be reduced as far as practicable. We have all known mothers of bottle-fed babies who had their babies brought to them only once or twice a day during hospitalization and who rarely had the experience of actually handling the baby or giving him the bottle.

I am sure I am not alone when I remember hearing a mother reproved for undoing her baby's clothes and looking him over "to be sure that he is really perfect."

Keep mother and newborn together

We can at least insist that the mother should feed her own baby, either from breast or bottle, and should not only be permitted, but encouraged, to keep him with her to fondle and love during the early days when both she and the baby need to develop a relationship that will make the early days at home free from feelings of strangeness and anxiety.

Now let us turn the searchlight on ourselves and try with frankness and honesty to see how we can improve our methods in respect to the mother.

I mentioned earlier the need of the mother to feel trust in herself. If I am right in this, we are making a serious mistake when we require of the mother the kind of absolute obedience to our dicta which is symbolized by the exact schedule: the requirement that all changes in feeding or routine should be authorized by the physician: the prescribing of exact amounts of this food or that, no more, no less: such and such hours for sleep: and even a fixed time for picking the baby up and fondling him.

Pediatricians, like many other people, often find satisfaction in this dominating role. They like to lecture the mother for using her own judgment and breaking some rule they have laid down. Mothers not infrequently use such a phrase as "I'm afraid you'll scold me," when they have only followed common sense in working out their problems. Certainly a mother who feels she must apologize for giving her baby more to eat when he is hungry, or picking him up and rocking him when he is unhappy, is a mother who is filled with distrust of herself and who spreads an atmosphere of insecurity about her.

Our insistence on frequent visits at which the baby is weighed and measured and a new set of rules is handed out is a way in which we satisfy ourselves, often with a minimum of benefit to the individual or consideration of his particular needs. We build up a group of dependent mothers who feel guilty at the least infringement of the rules laid down. We enjoy our power over them while complaining about their demands for advice concerning each little circumstance that may arise, and we groan over the number of spoiled brats we have to deal with.

Gradually, I have come to see the fallacy of the pediatrician's playing the part of the strict parent. I have had my troubles, for many insecure and immature mothers desire domination and even demand it. Fathers, too, have been at times disapproving.

I have become more and more convinced that the happy and contented baby is one whose mother feels free to adjust his schedule, the amount of his food, the hours for his sleep and play, according to her own day-by-day observation of the baby's needs. With this increasing assumption of responsibility and freedom to use her own judgment, her skill and wisdom increase: and minor variations in appetite, sleeping habits, or bowel habits do not fill her with consternation.

To encourage mother

I spend more time with the mother at each visit, have a long talk with her before she leaves the hospital when that is possible, and early teach her that if she observes her baby and notices what things make him comfortable and happy, she will soon become *the* great authority on *that* baby. No one else will know so much about him, and no one else will be as skilled as she in satisfying his needs.

She is advised to allow him to take the amount of food he seems to want, at the intervals that most conveniently meet the needs of the baby and the household. She is encouraged to enjoy him and to accept the fact that babies don't cry to irritate their parents, but as their only way of expressing their feelings of hunger or loneliness or fear or frustration, so that their need is for comforting, not for punishment.

She is led from the first to respect her child as a human being, whose inner drives are to be guided but not thwarted, whose need for love is as great as his need for food and who should never

be used to satisfy the selfish pride or competitive feelings of his parents.

As the baby grows older, the mother who has learned to accept him as he is can watch his development without trying to hurry it. She is free from compulsive and competitive drives in relation to his progress. She finds it easy to be patient with his fumbling attempts to feed himself, to dress himself, and to acquire the customs of the adults. Because of his love and his trust in them, he follows his strong imitative urge and accepts their mores.

He may show occasional healthy signs of rebellion and anger at the limits that are placed on his activities, but not many serious problems of behavior arise for the mother to cope with.

I am glad to find that most pediatricians are discouraging the mother in her attempts at early control of the baby's bowel habits. If one can assure the mother that there is no special virtue in the daily bowel movement, and that many babies are normal in every way in spite of a 2- or 3- or (as I once observed) a 5-day interval between evacuations, a great deal of unnecessary misery can be spared both mother and child. The baby who experiences throughout his first year the satisfaction of moving his bowels as the result of the demand of his own physiological mechanism, without interference as to time or place, rarely develops constipation or irregularities of defecation later.

To return again to my central theme, the relationship of the pediatrician to the mother of his patient: He should, I believe, offer her a source of strength and reassurance, be a friend to whom she can turn to talk over her problems and whose greater experience and objectiveness will help her to see these problems in their proper light. He is the guardian of both her child's physical and emotional well-being.

She can talk to him of anything from colds to masturbation and expect understanding and sympathy, and he in his turn must avoid the short-cuts of authoritarianism. He must encourage her to acquire the full maturity of her adult role, firmly insisting that she assume the responsibility of parenthood, teaching her to believe in herself, so that her child may find strength and security in her.

The happy and contented baby is one whose mother feels free to adjust his schedule, his amount of food, his hours for sleep and play, according to her own observation of his needs.

Reprints available in about 4 weeks.

MUSEUMS

(Continued from page 118)

ments out of cigar and cheese boxes and other discards.

Art devotees are equally numerous, and art and music go hand in hand in the museum's program. Children paint their responses to music, or to a dance. There are young people in Toledo who have literally grown up in the museum. Directors of the program feel that the seeds of culture sown in the minds of children flower in the life of the whole community.

The day I visited one children's museum I noticed a small boy whose interest in the exhibits seemed particularly keen. His brown eyes sparkled and danced as he darted from one exhibit to another. I learned that he is deaf and dumb. The museum is his greatest source of delight, and the infinite variety of things he can see and touch make up in part for his lack of hearing and speech.

Many museums give special attention to handicapped children. The Indianapolis (Ind.) Children's Museum has materials which can be handled by blind children, with large tags labeled in braille. Convalescent children from the hospitals are often brought to the Boston Museum, and loan boxes take treasures from foreign places to students of Perkins Institution for the Blind. Retarded children receive special attention in a number of children's museums.

How about your city?

Children's museums are not confined to larger cities. The idea is spreading, and many small places are developing museums. They start in various ways and are carried out under various auspices. Jacksonville, Fla., has a live and growing children's museum which developed from a few historical objects donated by a group of public-spirited citizens. It is a humming center of activity on week ends and during holidays. Among its interests are a fix-it shop and a toy-making group. The museum cooperates closely with the schools in science instruction.

Children's museums have an international aspect which is important. Through introducing children to an

understanding of the history, the way of life, of people of other countries, they do much to promote friendship and good will.

The United Nations is recognizing this potentiality for building bridges of understanding between the children of the different countries. A Children's Museum Committee, with 23 members from 10 countries, has been set up as part of the International Council of Museums under UNESCO. The committee met and reported at the meeting of UNESCO in Geneva in the summer of 1947. Part of this international program is to promote exchange of personnel and exhibits in museums of different countries. This exchange has already begun. The successful development of children's museums in this country has caused other countries to turn to us for advice and guidance.

That's another story

Little can be condensed into one article of the much there is to be told about children's museums. The story of the Washington (D. C.) Children's Museum, which unhappily lost its home, but turned misfortune into opportunity, and is now creating a new vogue in museums by converting temporarily to a trailer-coach museum, is a whole chapter in itself. It is one that must be postponed for another day.

The children's museum today represents part of what grandma and grandpa once passed on from their storehouse of memory, what attics yielded in ancient treasures, and the home library revealed of faraway lands, in a day when there were attics and home libraries and time to explore them. For children who live in a push-button, plug-in, mechanized world, in which wonder is almost a lost treasure, the museum has values that can hardly be estimated.

Children learn through seeing and doing, horizons are expanded through happiness, and the opportunities for creative expression and variety of experience foster emotional balance. Many times life interests, even choice of life work, grow out of the spare hours spent in the children's museum.

Reprints of this article will be available in 4 weeks, together with a reference list on children's museums.

BETTER MEALS

(Continued from page 121)

is given to each patient upon admission. The menus in these institutions are planned by the dietitians according to the meal patterns suggested in this pamphlet, which was prepared by the Maryland Dietetic Association in cooperation with the consultant dietitian of the Maryland State Department of Health. The pamphlet is intended to help the patients understand the "why" of the diet, so that they will be interested in cooperating with the sanatorium workers by eating the foods that are good for them.

What makes dietary consultation successful

In every case where the consultant service succeeded, the institution head really wanted this service, so that the children would be better fed. The best results were obtained when the superintendent of the institution designated some staff member to take responsibility for working with the consultant, or when the superintendent himself conferred with the consultant.

For the best results a regular schedule of visits was planned, and the staff member assigned for the conferences with the consultant worked out a plan in advance concerning the problems on which the institution wanted help. This staff member would take up the problems with the consultant and consider with her how her recommendations applied to the institution's special conditions and what was the best way to carry them out.

Employees concerned with the food service were free to ask help of the consultant, and those responsible for the service were allowed sufficient time to participate in the conferences.

In the institutions where the consultants had the greatest success in helping to improve the children's meals she was enabled to become thoroughly familiar with the food situation, including the amount of money budgeted for food costs and for related expenses. She studied the records of foods purchased or requisitioned, examined the stored foods, watched the cooking and serving of meals, tasted the dishes, and observed the children eating.

As a rule the consultant wrote a report of her study and recommendations and gave it to the institution, so that the staff would have something definite to refer to. For the best results these reports were filed in the institution for future reference. What use was made of the reports depended upon the administrator of the institution. In the interest of the children, and of the staff, we hope that the reports have been referred to often and used for their nutritional well-being.

A dietitian giving consultation service to institutions needs a good knowledge of human psychology as well as of institutional food administration. She must strive to make her suggestions in such a way that those concerned will want to put them into practice. The suggestions must therefore be workable.

She must be willing to show appreciation of the efforts of institution workers to do the best they know how; as well as to inspire them to want to do this. It is necessary for the institution to use the equipment on hand to the best advantage, yet the consultant must suggest what things it still needs for good service.

Making suggestions and getting them carried out requires a quite different technique from that of actually administering a dietary department. If the consultant is to establish a nutrition program she must also be skilled in methods of teaching.

Dietary consultation may also be advantageous in an institution that has a trained dietitian. The fact that a dietitian is on the staff does not necessarily guarantee a good diet, because the organization may be set up in such a way that she has no control over the ordering or serving of the food. If there is a farm program she may not be invited to discuss what is to be produced. Dietary consultation may help to correlate the activities of the dietitian with the business manager or steward and the farm manager.

The problems that face a dietary consultant are both numerous and complex, and their solution is never easy. However difficult they may be, they are always interesting, and when they are solved successfully the results are of such great value to the children in the institution that the work is well worth the doing.

Reprints available in about 4 weeks.

• IN THE NEWS

Committee Sets Training Standards for Vocational Counselors

A joint committee on educational and vocational counselor preparation met in Washington December 3–4, 1948, to define the basic content of adequate professional training for counselors. The committee included official delegates from eight groups concerned with counseling and guidance, as well as two technical consultants from each.

The groups represented were: American Psychological Association; National Rehabilitation Association; American College Personnel Association; National Vocational Guidance Association; State Supervisors of Guidance Services and Counselor Training; Veterans Administration; United States Office of Education; and United States Employment Service, Federal Security Agency.

A statement was agreed upon, listing seven "core" fields of knowledge to be acquired at the graduate level and considered essential to preparation for professional competence in counseling and guidance work. These are: (1) Philosophy and principles of guidance and counseling; (2) growth and development of the individual; (3) techniques used in the study of the individual for the purposes of counseling; (4) techniques in collecting and using occupational, educational, and other information; (5) techniques used in counseling interview; (6) administrative and community relationships; (7) supervised experience.

The printed report of the joint committee will be available for distribution at the national convention of the Guidance and Personnel Association, to be held in Chicago, April 18–21, 1949.

UNICEF Improves Health of Finland's Children

A noteworthy increase in the weight of undernourished Finnish school children who are receiving a daily supplementary meal through the aid furnished by the United Nations International Children's Emergency Fund has been reported by Finland's Department of Education. A recently completed survey, the department reported to the UNICEF Mission in Helsinki, reveals that UNICEF-aided children show a substantially greater increase in weight than those in localities not under the UNICEF program. At present, UNICEF is providing a daily supplementary meal for 80,000 Finnish children.

A total of 11,151 children were weighed regularly over the last 6 months. Of these 10,246 received UNICEF assistance and these gained an average of 2½ pounds during that time. In four counties in the district of Keski-Pohjanmaa (Middle Ostrobotnia) 950 children not receiving UNICEF aid were tested. Over the same 6-month period they gained an average of only half a pound, and in one school 255 actually showed an average decrease in weight of over 2 pounds.

The survey was the first made in Finland to find what results were achieved since the UNICEF program was set up in that country a year ago.

Finland is one of 12 European countries in which UNICEF is providing a daily supplementary meal for 4,500,000 undernourished children, pregnant women, and nursing mothers.

Georgia School-Health Project Approved

The Children's Bureau has approved an annual grant of $50,000 to the Georgia State Department of Public Health for the purpose of providing, in a rural setting, a broad program of preventive and corrective health services for school children, along with an expanded health-education program.

A school-health project will be established in a tricounty health unit consisting of Lamar, Pike, and Spalding Counties, with headquarters in Griffin, Spalding County.

This is a well-established unit, and a health-education program has already been developed in cooperation with the local schools. It is planned to add a full-time medical-social worker, a nutritionist, and a psychologist to the basic unit staff, which is also being strengthened by the addition of more nurses and dental hygienists. A part-time pediatrician and part-time psychiatrist are employed.

The project will be directed by the commission of the health unit, under the supervision of the director of maternal and child health of the State department of public health.

Nursery for Children of Nurses

A nursery for children of nurses at the Oklahoma Crippled Children's Hospital, Oklahoma City, believed to be the first of its kind in the United States, recently celebrated its second anniversary. It was established as a means of coping with the problem of decreased nursing staff. The project met with immediate success, and has been the means of augmenting the nursing staff by 12 nurses, who otherwise would not have been able to serve.

Alaska Continues Expansion of Health Services

Expansion of health services in Alaska continues as the Territorial Department of Health organizes to expand services under emergency appropriations obtained for such services in Alaska by the Public Health Service of the Federal Security Agency.

Among the high lights of interest to maternal and child health and crippled children's services are: A self-propelled barge which will operate on the Yukon and other rivers to provide medical and dental-health services comparable to the services provided by the Motor Ship Hygiene; a rail unit which will provide mobile-clinic services along the Alaskan Railroad; a survey of the need for a nurse-midwife program and the eventual establishment of such a program; and provision of new workers, including a school-health coordinator, a maternal and child-health consultant nurse, and staff for a local full-time health unit in Anchorage.

• FOR YOUR BOOKSHELF

STUDIES OF CHILDREN. Edited by Gladys Meyer, with an introduction by Dorothy Hutchinson. Published for the New York School of Social Work, Columbia University, by King's Crown Press, New York, 1948. 176 pp.

We all know that material based on direct observation of children and their parents, especially from the social-work point of view, is scarce.

The eight first-hand studies presented in this book, which were made by graduate students in the New York School of Social Work, are valuable additions to our fund of such studies. This is not only because of the scarcity of such material, but also because the students viewed the problems, as Dorothy Hutchinson says in her introduction, with freshness, enthusiasm, and imagination. As young students of social work, Miss Hutchinson says further, they are thoughtful, challenging, and as yet unencrusted by tradition.

Four of the eight studies are given in full. These are: Psychological problems of preschool children: an experiment in story-telling; the single woman as a foster mother; and telling adopted children. The other four are given in abstract.

The reports offer us some pointers toward conclusions on their respective subjects. They could well be supplemented by further studies in the same fields.

It is expected that from time to time selected studies will be presented by the school in the same manner. It will be a privilege to read them.

I. Evelyn Smith

CHILD LABOR TRENDS IN AN EXPANDING LABOR MARKET, 1946–48, by Ella Arvilla Merritt and Edith S. Gray. Reprinted from the Monthly Labor Review, December 1948. 7 pp. Available upon request from the Child Labor Branch, Wage and Hour and Public Contracts Divisions, U. S. Department of Labor, Washington 25, D. C.

Comprehensive statistical information on workers under 18 years of age is given in this statement for the postwar period up to 1948, including some figures for individual States, the first issued since 1944.

Its basic figures on young workers employed full time or part time are from the Bureau of the Census; and they include special figures on school enrollment and the employment status of minors 14 through 17 years of age.

Supporting data on industry and type of employment are from reports of employment certificates issued for minors 14 through 17 years of age by States and cities reporting to the Child Labor Branch of the Wage and Hour and Public Contracts Divisions.

Industrial-injury statistics are from a Department of Labor survey.

Data on illegal employment are from reports on child-labor inspections made under the Fair Labor Standards Act.

The Social Security Administration of the Federal Security Agency supplied figures on minors applying for social-security account numbers.

The conclusion of the article says:

On the whole, this statistical analysis of young people in the labor market during recent years reflects a sincere and widespread acceptance of the Nation's special responsibility for its younger population in respect to their place in school and their place in the labor market. But it also gives some indication of the shortcomings in measures to ensure educational opportunity for minors, to prepare them for satisfactory working lives, and to protect them from premature or harmful employment.

●

A limited quantity of each of the following items, reprinted by the Children's Bureau from sources outside the Bureau, is available for distribution. Single copies may be had without charge.

The Care of Children in Hospitals. By J. C. Spence, M. D., F. R. C. P. *British Medical Journal*, London, January 25, 1947.

Institutional Needs in the Field of Child Welfare. By Florence Clothier. *The Nervous Child*, April 1948.

Nutritional Status of Children. Six technical articles (III–VIII) of a series of eight, reprinted from the *Journal of the American Dietetic Association*. The titles and series numbers are as follows:

III. Blood Serum Vitamin C. By Elsie Z. Moyer, Ann P. Harrison, Marjorie Lesher, and O. Neal Miller (March 1948).

IV. Nutritional Conditioning in a Health Camp. By Moses Cooperstock, Elba Morse, Elsie Z. Moyer, and Icie G. Macy (March 1948).

V. Blood Serum Protein. By Eliot F. Beach, Ann P. Harrison, Marjorie Lesher, Mildred Kaucher, Charlotte Roderuck, Wanda Lameck, and Elsie Z. Moyer (May 1948).

VI. Blood Serum Vitamin A and Carotenoids. By Abner Robinson, Marjorie Lesher, Ann P. Harrison, Elsie Z. Moyer, Mary Catherine Gresock, and Claribel Saunders (May 1948).

VII. Hemoglobin. By Mildred Kaucher, Elsie Z. Moyer, Ann P. Harrison, Ruth Uhler Thomas, Marjorie Macy Rutledge, Wanda Lameck, and Eliot F. Beach (June 1948).

VIII. Blood Serum Alkaline Phosphatase. By Ann P. Harrison, Charlotte Roderuck, Marjorie Lesher, Mildred Kaucher, Elsie Z. Moyer, Wanda Lameck, and Eliot F. Beach (June 1948).

Understanding a Sick Child's Behavior. By Mildred Wallace, R. N., and Violet Feinauer. *American Journal of Nursing*, August 1948.

What's This About Punishing Parents? By Judge Paul W. Alexander. *Federal Probation*, March 1948.

"Where Shall We Send Johnny?" By Edith G. Seltzer. *Better Times*, December 26, 1947.

CALENDAR

Feb. 25–27—National Cancer Conference. Sponsored by the American Cancer Society and the National Cancer Institute, Public Health Service, Federal Security Agency. Memphis, Tenn.

Mar. 4–5—Children's Bureau Technical Advisory Committee on Programs for Care of Children With Rheumatic Fever and Heart Disease. Washington, D. C.

Mar. 7—Child Study Association of America. Annual conference. New York, N. Y.

Mar. 8—National Committee for Parent Education. Conference for Professional Workers. New York, N. Y.

Mar. 7–14—Young Womens Christian Associations of the United States of America. Eighteenth national convention. San Francisco, Calif.

Mar. 16–18—National Society for the Prevention of Blindness. Annual conference. New York, N. Y.

Area conferences, National Child Welfare Division, American Legion:

Mar. 4–5—Area A—Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, and Vermont. Boston, Mass.

Mar. 11–12—Area C—Alabama, Arkansas, Florida, Georgia, Kentucky, Louisiana, Mississippi, North Carolina, Oklahoma, Panama, South Carolina, Tennessee, and Texas. Jackson, Miss.

Regional conferences, Child Welfare League of America

Mar. 17–19—Ohio Valley Regional Conference. Cincinnati, Ohio.

Apr. 7–9—Eastern Regional Conference. Atlantic City, N. J.

May 1–4—Midwest Regional Conference. Chicago, Ill.

June 6–7—New England Regional Conference. Portsmouth, N. H.

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Page 124, Children's Bureau photograph.

MEET YOUR CHILD FROM 6 TO 12

By the time this issue of THE CHILD reaches our readers a new Children's Bureau publication, long desired by parents, will be off the press. This bulletin, Your Child From 6 to 12, is the fourth in our basic series for fathers and mothers.

The first of this series for parents was Prenatal Care. It came out 34 years ago, within 16 months after the Bureau was created. Prenatal Care was not the first publication of the Children's Bureau; during the year when the Bureau was getting under way it published several pamphlets for professional workers. But Prenatal Care was the first of the Bureau's publications for fathers and mothers.

No sooner had Prenatal Care gone to press than the Bureau went to work on its second major bulletin for parents, Infant Care, which came out a year later. Infant Care, which is now the most widely known of all the Bureau publications, has been translated into many languages. Like all the Bureau's major bulletins for parents, it has been revised often to keep it up with the newest scientific thought. (It is now due for another revision.)

Next after Infant Care came a bulletin called Child Care, the Preschool Age. This came out in 1918, while the United States was at war. The most recent edition, issued in 1948, is titled Your Child From 1 to 6.

Thus, in the early years of its existence, the Children's Bureau supplied the fathers and mothers of the United States with comprehensive publications to help them in caring for their children from the time before birth up to their sixth year, as well as a number of brief folders.

But up to now we have given fathers and mothers no major bulletin concerning their children between the ages of 6 and 12. Many parents and other people have written letters asking the Bureau to issue a publication on children of this age group.

This bulletin has now come out, under the title, Your Child From 6 to 12.

It would be impossible in a pamphlet of 140 pages to cover all the topics and questions that interest the parents of children at this interesting stage of life. What the Children's Bureau has aimed to do is to emphasize a point of view. Instead of seeing the child as standing by himself, this publication considers him in his family setting.

These years are the last in which his family is the main source of influence on the way a child unfolds and develops. To make family life contribute all it can to the enrichment of their children's personalities is what thoughtful fathers and mothers try for.

There is no blueprint as to how parents can help their children to achieve a satisfying relationship to the world into which they are gradually emerging, but Your Child From 6 to 12 has been written in the hope that it will stimulate fathers and mothers to acquire a growing confidence in their ability to do a successful job.

In his introduction to the bulletin, Oscar R. Ewing, Federal Security Administrator, says:

"Innumerable books, pamphlets, and articles have been written—and rightly—about the infant, the toddler, and the preschool child. Only a few articles and fewer books have been devoted to the school-age child, however.

"Yet that 6–12 period is as important as the years that have been passed. The 6-to-12 child is still close to his parents. He still appreciates attention, love, and sympathy. He is striking out for himself, making friends, exploring his world. He is on the way to becoming a self-directed, self-motivated individual.

"Distressed at the lack of the written word about that important school-age period in their children's lives, parents in ever-increasing numbers are seeking help in the guidance of their school-age children.

"As a means of helping fill their requests, Your Child From 6 to 12 is offered."

VOL. 13 No. 8 FEBRUARY 1949

the CHILD

published monthly by the
Division of Reports
CHILDREN'S BUREAU

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Publication of THE CHILD, monthly bulletin, was authorized by the Bureau of the Budget, May 12, 1936, to meet the needs of agencies working with or for children. The Children's Bureau does not necessarily assume responsibility for the statements or opinions of contributors not connected with the Bureau. THE CHILD is sent free, on request, to public officials and libraries. For others the subscription price is $1 a year. Single copies, 10 cents. Send remittance to the Superintendent of Documents, Government Printing Office, Washington 25, D. C.

U. S. GOVERNMENT PRINTING OFFICE: 1949

MARCH · 1949

the CHILD

WORLD UNDERSTANDING BEGINS WITH CHILDREN

KATHARINE F. LENROOT *Chief, Children's Bureau*

IN his new book, The Proper Study of Mankind, Stuart Chase refers to the dominating drive of social scientists "to develop world men who can rise above their culture and see the planetary shape of things." "Such men," he adds, "can be against Martians, or soil erosion, or typhus, or slums or famine—but they cannot be against men."

We are living in an era when material force has reached the maximum expression yet known to history. Yet a high degree of moral leadership and social organization had to direct that force in order to win the war against Nazism and Fascism. Today the world is divided. Instead of peace we are in a period of an armed truce, which many careful observers predict will last a long time. During this period it will be necessary for the United States and other western nations to be prepared in a military sense. Yet though we may buy time with military preparedness, the outcome will be determined, not by force but by demonstration of the superior values of democracy and freedom.

To show value of a free social order

In the occupied zones of western Germany the victorious powers have a monopoly of physical force, but they know that the success of their occupation depends upon the extent to which the German people become persuaded of the validity of democratic philosophy and concepts. The "democratization" of German thought and German life has a central place in the objectives of those in positions of responsibility.

We are in the paradoxical position of attempting to use material power to provide an opportunity for the nonmaterial methods of persuasion through demonstration of the superior values of a free rather than an authoritarian social order. In his book just published, Education in a Divided World, President Conant of Harvard says:

"If my diagnosis is correct, our fitness to survive in a divided world is related to the power inherent in our traditions. Our future national strength depends to a large measure on wise and intensive cultivation of those elements in our democratic culture which are peculiarly our own. At the same time the responsibilities of world leadership require us to extend the boundaries of our interest and our sympathy as never before. We must formulate the goals of our free society in terms consistent with our past, yet force our imagination to leap two oceans. For if we are to combat the Soviet philosophy on other continents, not only must the morale at home be high but our foreign policy must be farsighted and courageous."

The idea of freedom and the basic reliance upon the power of persuasion over force is inherent, though incompletely expressed, in western civilization.

American democracy, Conant says, is in part a fact and in part a dream, and the latter is as important as the former.

The child must be first

We, unlike the people of many other nations, live in a society that is highly conscious that it is a "becoming" rather than a finished product. And because this is so, highest priority must be given to the persons of that age group which is supremely the period of growth—namely, the children.

To quote President Conant again, "Equality of opportunity means equal opportunity for the youth of each generation; the phrase as applied to adults has little or no meaning."

Given at the Colorado State Conference of Social Work, Denver, November 18, 1948.

If we are to demonstrate our fitness to survive in a divided world, we must do everything possible to strengthen the determination of all citizens that every child born into the world under the American flag, regardless of race, creed, color, geographic location, or economic circumstances, have his fair chance in the world.

Almost 30 years ago Julia C. Lathrop, first Chief of the Children's Bureau, called child welfare "a test of democracy."

As others see us

We will be judged by the peoples of other cultures to a large extent by the degree to which we make this cornerstone of the American dream a reality. They will be helped to understand us as they sense our sincerity and our courage in advancing toward our goal of equal opportunity for all youth. They will doubt the inner strength and stability of our civilization to the extent that they see us hesitant, wavering, and confused in relation to our goals for children.

It is not only that through the opportunities afforded to children, and the care they receive, that we must demonstrate our adherence to the principles of freedom, individual worth, and equality of opportunity both before the law and in relation to health, education, and economic and social well-being.

For peace and freedom

The first fruit of our success will be the development in children of those capacities to live with themselves and with others that are essential if our children are to grow to be effective instruments for the advance of our civilization and the development of a free and peaceful world.

We have plenty of evidence in this country that ill-educated, economically disadvantaged, unhappy, and frustrated people have difficulty in getting on with

Eastern and western countries are cooperating with UNICEF in administering child-feeding, medical, and other projects, without discrimination because of race, creed, or political belief. To millions of children the United Nations, through the fund, means tangible concern for them.

others in their own communities, to say nothing of the world at large. Mountain feuds, race hatred, anti-Semitism flourish when people are left behind in pockets where isolation leads to backwardness or disintegration.

Peace begins in the minds of men

Education for international understanding and cooperation must begin, not in college, not in high school, not even in nursery school, but in the cradle.

Some time ago a regional conference was held in Colorado, under the auspices of UNESCO, to bring home to the people the purpose of this great agency of the United Nations. It is founded on the principle that the basis for peace is in the minds of men. Leaders are beginning to recognize the fact that to establish this basis we must begin with children.

In The Proper Study of Mankind, Stuart Chase suggests "a gigantic project to make a plan for permanent peace." As the first step toward such a plan we need a great effort to mobilize our resources for (*a*) the study of the growth and development of children in the cultures in which they live, and the ways in which they can best be equipped to advance the purposes of our developing American democracy and its contribution to permanent peace, and (*b*) the development of governmental and voluntary action needed for the application of knowledge in relation to childhood and youth as rapidly as it is accumulated and tested. We hope that preparatory work for the Midcentury White House Conference on Children and Youth and the conference itself will help to awaken the public to an awareness of the urgent need for this gigantic effort and to chart the course that it might take.

To encourage research in child life

To be successful such an effort must enlist the participation of scientists and professional leaders in many different fields, including medicine, psychiatry, psychology, law, education, cultural anthropology, economics, sociology, and social work. The "team approach" is needed in both research and the administration of services. In the past year the Children's Bureau has had a series of conferences with social scientists in many fields, considering the areas in which research in child life is most needed and the ways in which it can be further developed. In accordance with recommendations growing out of these meetings, the Bureau is inaugurating, on a small scale, a clearing house of information on research projects, under way but not yet published, in all aspects of child life and child development.

Love is essential to the child's health

We know already that the outgoing, enfolding, unselfish love of emotionally mature parents is the soil in which the personal security of the child grows. To this understanding the professions of social work and child psychiatry and psychology have contributed much. Such security is the basis for successful participation in family and community life and in the affairs of the Nation and the world. A concerted effort to surround all children with the kind of love that is essential to both their physical and mental health, and to provide expert help for parents and their children, if they need such help, could remake the world.

Social order based on dignity of free man

A society that recognizes the rearing of children as its most important task will test all social institutions by their effect upon the emotional security of childhood. Does the care given the newborn infant and his mother directly encourage the warmth of relationship between mother and child which is so important from earliest infancy? Do the conditions of family life, the relationships between parents, their relationships to their children, the housing available to the family, the responsibilities that the mother may have for earning part of the family income, interfere with or promote the fulfillment of the emotional needs of the young child? How can the conditions of family life be modified so as to make it possible for children to have greater security?

The second need of the child is for an example, a pattern by which he will build as he grows in experience and independence of thought and action. We must not only give children emo-

tional security; we must enable them to identify themselves with parents, teachers, and civic leaders who are united in a great effort to establish a social order throughout the world based of the dignity of the free man and his responsibility for the common good.

Preschool influences affect child

President Conant thinks we need to turn loose a group of young social scientists to study our educational system, and that education must be evaluated in the light of the total situation in a community.

"For example," he says, "the investigators of a given educational situation must ask all sorts of questions about human relations among students and their families; they must also seek information about the unwritten conventions and customs that determine to a large degree the behavior of individuals."

In other words, the make-up of the child as he comes to school, carrying within him the experiences of home and neighborhood, and the example which he finds in those he comes in contact with as they express unwritten customs and conventions are antecedent to the question of the kind of educational program he finds in the school.

Bringing opportunities for general technical and professional education within reach of all, removal of economic barriers to education, and development of adequate guidance services in schools are essential if education is to serve our modern age.

World understanding requires not only appreciation of the values and contributions of cultures other than our own, but also accurate appraisal of the forces making for division and conflict.

In considering the specific ways in which education can promote the aims of democracy, President Conant lists study of Soviet philosophy as "the number one educational need of the present moment."

He also urges study of other countries and world problems. "A knowledge of world geography," he says, "of European history, and of the culture of the Far East must be provided to some degree at every level of the educational process."

"One of the very difficult problems," he adds, "is how some knowledge of these complicated matters, involving a mass of detailed facts, can be supplied as part of a general education."

Having considered some of the ways in which enhanced effort for the well-being and opportunity of our own children will promote world understanding and the world peace, let us see how the foreign policy of the United States and the work of the United Nations must include in increasing degree concern for the welfare of children.

For about 8 years the Children's Bureau has participated in a program of cooperation with the other American Republics in scientific and cultural fields, under the auspices of the Department of State and the Interdepartmental Committee on Scientific and Cultural Cooperation.

To compare experience

In small numbers, people in responsible positions in other American countries have been aided to come to the United States for study and observation of our methods and comparison of their experience with ours: in turn, people on the staff of the Children's Bureau have been made available to other republics, on their request, to assist in the development of their health and welfare programs.

A law enacted January 1948 authorizes similar cooperation with countries of Europe and the Far East.

Similar activities on a world-wide scale are now made possible by the United Nations and its specialized agencies. This year the Children's Bureau is undertaking to give such service to a limited number of persons from Germany. Programs for persons coming to this country for study and observation are made possible only through the generous cooperation of State and community agencies.

Workers find visits helpful

It is impossible to assess fully the value of this kind of international interchange, in child welfare, social security, education, health, and related fields. Some of the letters that come to the Children's Bureau from observers who have returned to their own countries illustrate how much such programs can mean.

For example, a health worker from India who had visited the Children's Bureau wrote us as follows:

"In the busy days of yours, perhaps you might be forgetting us, but we will never forget the most interesting and valuable time we had together when we were visiting the U. S. Public Health Service and Children's Bureau in August 1947. * * * The detailed information and material we had collected from you helps us a great deal in our work here. Our library is full of Children's Bureau publications. * * *

"My country and particularly my State being poor, we need this initial help from you to start the work. I want authentic and scientific literature to be distributed to the various health centers we are building up through the Department of Public Health."

A returned visitor from the Philippines describes in a letter the various responsibilities which have been imposed upon the group which had visited the United States. She writes:

"There is so much work to do and plenty of ground to cover that the job seems endless. However we all feel that our stay and observations in your country have been of much help to us in carrying on our respective work here."

A South American pediatrician visiting child-health and welfare agencies in the United States about the time of the San Francisco Conference which set up the United Nations, wrote in substance:

"In this hour of world organization I have more faith in the international work for the benefit of the child that is being done in many places than I have in Dumbarton Oaks or San Francisco. After all, the latter in fact depends upon a human factor, but the work for children relates to the human factor itself, from its early roots, from its first hours of life."

The United Nations International Children's Emergency Fund is proof that concern for children transcends all political barriers, even an "iron curtain." Meetings of the Executive Board of representatives of 26 countries are characterized by a minimum of political debate and a high degree of unity of purpose. Eastern and western countries are cooperating with the Fund in

(Continued on page 142)

BALTIMORE'S TEMPORARY GROUP HOME HELPS TROUBLED CHILDREN

DOROTHY CURTIS MELBY

Supervisor of the Children's Division, Baltimore City Department of Public Welfare

SOME CHILDREN who have to be cared for away from their own homes stand the transplanting better if they go to live for a while, not in a family home, but with other children in a group home.

Take, for example, a child who has never known what it is to take a bath, to go to bed at a regular hour, to sleep between sheets, and to eat three meals a day. Such a child may learn to do all these things with less resistance in a group of children than in the closeness of a family home.

Then there is the child who is devastated by the loss of his parents and his home. Such a child finds in a group home that he is not alone in his experience. Besides, a group home, with its congregate living, is so different from his own home, or any family home, that he is not likely to make comparisons between them. This is true also for the child who has had to leave a foster home on account of the death of the foster mother or because the foster parents find him so difficult that they ask to have him taken away.

Sometimes a child who must be cared for away from home has such a strong emotional tie with one or both parents—whether a beneficial tie or a harmful one—that he would find it impossible to establish good relations with a foster father and mother. A child of this kind, if placed in a group home, shares a house mother with a dozen other children. He has a chance to be with a number of adults who do not have the emotional stake in him that his own parents have and who do not demand of him as much response as a foster father and mother would.

Given at the National Conference of Social Work, held April 17–23, 1948, at Atlantic City, N. J.

About 40 of these and other types of difficult, troubled boys and girls, 6 to 16 years old, live, in a constantly changing group, for periods ranging from 6 months to a year, in a group home called Cylburn, which is conducted by the Children's Division of the Baltimore Department of Public Welfare.

Cylburn was not started with its present purpose: that is, to place selected children in group care and to give them every opportunity for development until they are ready to live successfully in family foster homes. Instead, it began merely as a shelter home, when no foster homes could be found quickly, for children 2 to 16 years of age who were committed by a court to the department of public welfare. (At that time, in 1943, the Department of Public Welfare had been in existence only 8 years, and the Children's Division only 2 years; and our temporary foster homes had not yet been developed.)

It was first thought that the children would remain 2 or 3 weeks in Cylburn, and then move into foster homes. But foster homes were as scarce at the end of the allotted time as they were on the day the child was committed. Besides, the workers noticed that some children seemed to profit through living with other children. And so the children were kept in Cylburn longer than had been expected.

It is impossible for any agency that cares for children not to examine frequently what it is doing, and to try to improve it. And so Cylburn in its 6 years of life has been constantly changing in concept and in practice.

The house and grounds

Cylburn, the 200-acre estate where these children are under the care of the Children's Division, was originally bought by the Park Board of Baltimore for future park purposes. It gives its name to the institution.

Cylburn's lawns, fields, and woods are ideal for children's outdoor activities. But the three-story house on the estate, a fashionable home of the nineties, is an austere stone mansion with large, high-ceilinged, dark rooms that were never meant to house children.

To transform this forbidding house into a welcoming, livable home for chil-

dren has taken time, imagination, and money. Old floors have been covered with bright linoleum, and dark walls and woodwork have been painted sunny colors. Though the inside of the house is now hardly recognizable as the Victorian mansion of other days, much must still be done, and some changes that are necessary to make it truly a children's home can never be made.

Finding staff for the shelter in the first place was no easy task, and as the purpose of the institution has changed from giving temporary shelter to providing group experience for certain children, the type of personnel has of necessity changed.

Although the institution is under 6 years old there have been three different superintendents. It was not until June 1947 that a superintendent was found whose chief interest, experience, and training were in the field of group living for children. Needless to say, it is since then that we have made the greatest progress in the care of the children.

All employees come under the city merit system. Qualifications have been set up for each job, and an examination is required of each person meeting these qualifications.

A staff of 11 people is deemed necessary. At present there is the superintendent, who is a man, and the assistant superintendent, his wife; a senior house father with over-all recreational responsibility; four house mothers, a general housekeeping helper, a cook, a janitor, and a laundress. The superintendent is directly responsible to the supervisor of the Children's Division of the Department of Public Welfare and works with her through weekly conferences. Besides having over-all responsibility for the institution, the superintendent works directly with all the house parents through staff meetings and individual conferences. The assistant superintendent is responsible for supervising the housekeeping staff and for purchasing the children's clothing and keeping it in repair.

In addition to having an administrative staff and house parents that have an understanding of children and an ability to live and work with them, it is important that the institution also have a maintenance staff with the same qualities. The cook, for example, not only has the responsibility of cooking the meals, but works with the children in the part they take in the kitchen chores. Whether the work is a satisfying experience for them largely depends upon the personality of the staff and their ability to get along with children.

Children are given duties to help them learn to take responsibility, not to lighten staff work.

The role of case workers

Children like these troubled young residents at Cylburn need the help of a case worker. The institution has no case worker on its staff, but each child does have the help of a case worker assigned to him by the Children's Division. As many as six or eight case workers are likely to be serving Cylburn's children at any one time, and these workers change as the children come and go.

The problem of the best way to give the children case-work help is still unsolved. Question after question on this point arises, among them these: Should the home have a case worker on its staff to help the children with their living experiences within the institution—to help them get the maximum advantage from everyday living with a group of children? If the home had this staff member, to whom would she be responsible? From whom would she get supervisory help?

Should a child's case worker change when he enters and leaves Cylburn? (This would happen if Cylburn had a case worker.)

Would the children there get more help from a case worker who gave service only to children at Cylburn or from one who served also children in foster-family homes, as under the present plan? If a case worker on the Cylburn staff worked with the children's parents, how could she help solve the whole, many-angled problem of placement?

Having a changing number of case workers serving children constantly (at present seven workers and four supervisors), and having this system work well for the children, poses a problem for the staff at Cylburn. As one way of attacking the problem, case workers and institution staff discuss matters having to do with the children that are their common concern.

The discussions take place at regular meetings of the superintendent, assistant superintendent, house parents, case workers, supervisors, and the supervisor of the Children's Division of the Department of Public Welfare.

Questions like the following are talked over in terms of individual children: What does a house parent need to know about a child in order to help him live in a group of children? What do the relations between a case worker and a child mean to the child as he lives

in a group, as he does at Cylburn?

These and many other questions, some more general and some intensely specific about an actual incident, are the concern of staff and social worker, each from the viewpoint of his particular responsibility.

The goal of all our activities is to give every possible opportunity to each child for natural growth and development.

In the first 2 years the struggle for sheer existence was all absorbing. The house furnace didn't work; the staff was inexperienced; the children were of wide age range and had a great variety of troubles. But gradually, as the environmental difficulties diminished and we began to plan satisfying experiences for the children, we realized that we were making a grave mistake. We were asking 12 children of nursery-school age to live 24 hours a day in an overstimulating atmosphere. Each child not only shared one house mother with 11 other children, but also had a succession of other adults caring for him while his house mother was off duty. The children lived in an atmosphere of boisterousness that any group of 38 children of different ages can create. And so in the belief that no very young children could benefit from this kind of living, the lower age limit was changed to 6 years, leaving the span from 6 to 16 years.

Giving a sound group experience

When we stopped taking children from 2 through 5 years, we began to examine what we needed to do to give the older children a satisfactory living experience. Certain things needed to be done, whether the institution was for short-time shelter or for planned living over a somewhat longer time. We began to move definitely toward giving each child help from group living. We could not let the time he spent at Cylburn be merely a waiting time till a family home was found or till his own parent or parents reestablished a home. We needed to consider what we could give a child each day while he was in the institution.

Not even at the very beginning were the children regimented. At no time has the staff planned to organize the children so as to make their own work lighter. The children have always had freedom to express themselves and freedom to play anywhere in the house or near it. But in our effort to give full freedom we have had the inevitable result of giving more freedom than a child can bear.

At one time a child's day was not well-enough organized to give him a feeling of security. Indeed, as we try to make Cylburn an institution for beneficial group living, one of our major problems seems to be: How to achieve a framework of organization within which a child may have only the kind of freedom that he can use with profit.

Of one thing we are sure—that each child must be able to depend on, and should be required to accept, regular hours of eating, sleeping, working, and playing. And carrying out these necessary everyday activities at regular hours must be made satisfying to him. His group experience in going to bed, for example, is as important as being with other children in a craft class, if not more so.

We are sure also that he must have a house mother who is as dependable as the clock itself. He must know that she will always be waiting for him when he returns from school and that she will be interested in him and in what he is doing, thinking, and saying.

And his house mother must require of him certain accomplishment. She will provide clothing for him that is in good repair, but she will also require him to care for it. She will require him to come to meals on time, but first she will be responsible for making mealtime a pleasant social experience. (It is taken for granted that the food will be good and will be attractively served.)

Any effort to plan for children living in a group should attempt to achieve a balance between time for work, time for play that is planned and supervised, and time when they may do nothing if they choose.

Certainly an appropriate balance has been hard to achieve at Cylburn. How much work should be required of a child so that he gains a sense of responsibility for himself as a member of a group—indeed, as a member of society? When does the amount of work go beyond what a child needs and become based on the need of the institution for his service? How much should a child be required to do for himself and for his group in relation to clothing, food, and living quarters? These necessities of everyday living become the foundation of either helpful or harmful group experiences.

But over and above what children should do for themselves and for the group, they should take part in other satisfying activities. Real planning on the part of the staff is necessary to meet this need. Here again a balance should be achieved—this time between physically active outdoor and indoor play and quiet, thoughtful recreation. Children should have enough stimulation to be satisfying, yet not enough to create tense excitement. A balance in play must be worked out, as well as a balance in all the other factors that go to make up a child's happy day.

Group experience in the children's everyday lives is important to their natural development.

Living at Cylburn is an experience in which we of the Children's Division hope that each child will gain something of what he has lost in his unfortunate experiences before he came to the institution. Toward this primary purpose, a child may have to learn to trust adults; to live and play with other children; and to respect and believe in himself. Therefore in his life at Cylburn contact with the larger community is very important. And so he goes to public school, to Sunday school, to the movies, and to other places where children gather. He takes part in community activities with the children in his school and Sunday school. It is very important that while a child is living at Cylburn he should gain a sense of being like other children and of "belonging," just as they do.

Quiet recreation in the evening is part of group experience for these youngsters at Cylburn.

Application and selection

The change in assigning children to Cylburn shows most clearly the metamorphosis of Cylburn from a shelter home to a group home.

When Cylburn opened, the Children's Division of the Department of Public Welfare had no application department. Children were committed to the agency by the court and often had to be placed that very day. Any child committed was likely to be sent directly to Cylburn if there was a vacancy.

Now all applications for placement in Cylburn are received in the application department of the Children's Division. The workers in that department deal with parents only, not with children. They study with parents not the specific question of whether a child should enter Cylburn but the whole problem of separation from him—whether it is best to have the child committed to the Department of Public Welfare by the circuit court for placement. When a parent and the agency have reached a joint decision that placement seems to be the best solution for parent and child, the case is referred to the department of temporary care. The district supervisor and the casework supervisor of this department determine with the parent whether the child is to be placed in a temporary foster-family home or at Cylburn. Every effort is made to place only those children at Cylburn who can profit by living for a while in a group.

How the children change

It is surprising to us that in spite of our inexperience in running a children's home, of our blunders, of our shortage of workers and the frequent staff changes, and of our lack of program, most of the children have gained something substantial for themselves from living there. Through the help of a case worker and the institution's staff, children have changed from belligerent street-urchins into children acceptable for placement in a foster-family home. Children have learned to be children, to get satisfaction from playing children's games with other children of their own age instead of sex activities and begging in taverns.

Our task ahead

A few children have found no satisfaction in the group life of Cylburn. This is partly because we did not provide what they needed and partly because they had deep-seated emotional difficulties requiring treatment, possibly in a psychiatric hospital.

We know that we have given no child enough, but now our staff is better qualified for the work, and more stable, we hope that we can begin to refine our day-to-day process.

We are beginning to be more thoughtful and responsible about the way a child is prepared for coming to Cylburn, the way he is received, and the way he leaves.

We are being more responsible about each child's part in the day-to-day living at Cylburn. He is having more choice in his clothing and more responsibility for caring for it. We are hoping to plan for his taking part in self-government, being mindful of his limitations. We are starting to keep for each child a record of his living at Cylburn; heretofore there has been only the case worker's record of the child, kept for the Division's use.

This group living is offered as part of the foster-care program of the Children's Division of the Baltimore Department of Public Welfare, in addition to care in foster-family homes. We of the staff of the Children's Division feel that we are now on the brink of being able to give a stable, beneficial background for living to those children committed to the Division's care who need and can use with profit a short-time group experience.

Reprints available in about 4 weeks

MEMPHIS ATTACKS ITS RHEUMATIC-FEVER PROBLEM

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ONE of the bright spots on the American scene is the constantly widening scope of community planning in the field of health. Through the stages of municipal sanitation, control of contagious diseases, and the furnishing of immediate medical care for those unable to pay has evolved the concept that a community also has obligations to those of its citizens who are chronically handicapped by disabling conditions.

The city of Memphis, attempting to meet one aspect of its obligation to its small handicapped citizens whose parents are unable to arrange for proper attention from private physicians, has taken steps to solve the problem of rheumatic fever in children, as part of a broader community plan for child health, in which many public and private agencies are sharing.

The rheumatic-fever problem that the city is attacking is the disease as it occurs in children under 13 years of age who are residents of Memphis and Shelby County, who are not under care of a private physician, and who attend the out-patient department of the John Gaston Hospital (the city hospital) or are admitted to the hospital itself.

Rheumatic fever is by no means a rare condition in the South (Memphis is no exception to the rule), though the disease does not strike so frequently as it does in colder climates. Among the children we are considering, about 2 percent either have the disease or are suspected of having it. For example, in the past 5 years 200 children were seen in the clinic or the hospital who were diagnosed either definitely or tentatively as having the disease.

Despite the frequency with which rheumatic fever occurs in the children of the city, and the severity with which it strikes, no organized attack on the problem was made until 1947, when a special rheumatic-fever committee was established as a subsidiary of the health steering committee of the community council.

The rheumatic-fever committee consists of physicians from the University of Tennessee, others in private practice, social workers, medical-social personnel, public-health representatives, and persons representing other civic groups.

Through the efforts of this committee a children's heart clinic was organized.

The first group to come under the surveillance of the new children's heart clinic was the backlog of 200 children who had been suspected of having rheumatic fever.

Intensive efforts were made by the social-service department of the John Gaston Hospital and the junior department of the Nineteenth Century Club (a woman's club specially interested in children's health) to locate and bring these children back for study. Many had moved and could not be located, but the majority were found and their cases reviewed.

In many instances, it was clear on further study that a diagnosis of rheumatic fever was not tenable, so that the total number of children in whom the diagnosis was substantiated fell considerably short of 200. Nevertheless, there are more children with the disease than one likes to think of and they constitute a sizable problem.

Often during the acute stage of rheumatic fever the child needs to be cared for in a hospital.

Owing to the efforts of the public health department, a drive has been going on through the visiting nurses' group to bring to the new clinic all children suspected of heart disease. This has brought to light many children with congenital heart disease, some of whom can be helped by surgery.

As was to be expected, many children with functional heart murmurs have been weeded out from the group with organic disease of the heart.

Many diseases may simulate rheumatic fever. One such disease is sickle-cell anemia, which is prevalent in Memphis.

Serious difficulties found

The problem of rheumatic fever in Memphis children has been approached from four angles:

1. Diagnosis, which implies proper facilities and personnel for this purpose.
2. Hospitalization facilities for the acute or active stage of the disease.
3. Convalescent facilities for the subacute stage.
4. Follow-up supervision of patients.

In all four of these major aspects of management of rheumatic fever serious deficiencies were encountered. Facilities for diagnosis needed improvement—not only better equipment but also more careful medical supervision. Hospitalization facilities for children in the acute or active stage of the disease process were none too good. Convalescent services were lacking, as they are now. Follow-up supervision of the patients was not being carried out.

Typically a child with rheumatic fever had been seen in the out-patient department or admitting room of the hospital, was hospitalized during the acute stage in crowded surroundings, sent home as soon as the immediate condition permitted, and not followed in the home. Subsequent medical examinations, with few exceptions, had been given him only if new symptoms arose, or if former ones returned.

The following steps have been taken to improve conditions with regard to rheumatic fever:

In the new children's heart clinic, not only children with rheumatic fever but also those with congenital and other types of heart disease now receive special supervision. Furthermore, any child suspected of having heart disease is sent to this clinic to determine the presence or absence of significant heart involvement.

At the present time, the clinic meets every other week, but the number of children who are being seen is increasing so rapidly that it will soon be necessary for it to meet every week.

Space for the clinic activities has been acquired in the out-patient department, adjoining the hospital. There are waiting rooms for these children separate from the general clinic waiting room. This decreases the opportunity for cross-infection.

The medical personnel of the children's heart clinic consists of three to four pediatricians who are members of the staff of the university, and six pediatric residents. Two nurses assist with the records and in the management of the patients.

Volunteer workers assist as clerks. In addition, they help the hospital social-service department to contact the patients for clinic appointments, and, when the weather is inclement, transport the children to and from the clinic. This latter service is invaluable, considering the dangers rheumatic patients face from recurring attacks of sore throat.

The junior department of the Nineteenth Century Club has adopted, as its permanent project, the field of heart disease in children. These women learned of the need for better X-ray diagnostic facilities, which would enable children to obtain an improved and a more easily available service. As a consequence, the organization gave approximately $8,000 to the city of Memphis to equip a special cardiac diagnostic laboratory, which is chiefly an X-ray room. Through the kindness of an X-ray equipment company a very fine machine was obtained at a marked reduction. The new room, worth about $12,000, is a part of the suite of rooms of the X-ray department of the John Gaston Hospital.

A step forward

With the new X-ray facilities children can be handled as a special group, appointments for examinations are readily filled, delays are at a minimum, and children can be seen without having to wait in the general waiting room, where they would be exposed to the hazard of cross-infection. In this new room children who have been singled out for fluoroscopy and X-ray films in the clinic are examined at the end of the clinic session. A bronze plaque in the shape of a heart is on the door of the room, bearing the words: "That the Hearts of Children May Be Made Glad Again." The problem of obtaining adequate X-ray facilities has been solved.

The same club group also gave $800 for an electrocardiograph machine for the children's heart clinic. Previously electrocardiograms were difficult to obtain because of the long list of patients waiting for this service. Now the tracings are taken after the clinic sessions, and the machine is also available at other times in the Children's Hospital.

Laboratory facilities for serology, blood counts, urinalyses, sedimentation rates, and so forth, are quite adequate and offer no problem.

Children with rheumatic fever in the active stage are hospitalized in the Children's Hospital.

New children's hospital needed

Every effort is made to isolate these patients from children with acute infections, and there have been surprisingly few cross-infections to rheumatic patients. Still, when the hospital is crowded, the rheumatic-fever patients are not shielded from the possibility of cross-infection as much as would be desirable. No solution to the problem is seen until a new children's hospital is obtained.

Increase in the number of pediatric residents after the war has resulted in much closer supervision of all children in the hospital, and has meant that there have been very few delays in getting patients of all sorts discharged as soon as their conditions permitted. Previously, a small, overworked staff was unable to cover the cases so completely, and delays occurred which led to overcrowding of the wards. The wards are much less crowded now, and, therefore, the rheumatic-fever patients have more space and better protection.

The crux of the problem of rheumatic fever in Memphis and Shelby County is the lack of facilities for convalescent care. There is no need to dwell on the importance of such facilities, for it is widely recognized that no successful

rheumatic-fever program can exist without proper arrangements for convalescence. Memphis at present totally lacks convalescent facilities for children with rheumatic fever. The city is bearing an unnecessary financial burden in keeping such children in the hospital after the acute stage of the disease is over, when they would do much better in a convalescent home.

The picture is not so dark as it seems, however. One of the largest organizations in the city is planning to build a convalescent home, or to buy a suitable residence and convert it into a convalescent home, retaining title to the property. This organization would not be able to contribute to the annual budget of the convalescent home, and it has been advised to wait until means are found to support this budget.

For a convalescent home

The greatest need at present is for funds to support the annual budget of a suitable convalescent home. The budget would include not only the cost of food, laundry, heating, lighting, and maintenance of the home itself, but also the salaries of a cook, a maid, full-time nurses, a full-time medical-social worker, and a recreation worker. A teacher could be supplied by the city. Medical supervision would be by the pediatric department of the University of Tennessee. A senior medical student or a pediatric resident would live in the convalescent home in order that the children would have medical attention available at all times. Staff members of the pediatric department would be assigned to the convalescent-home service.

No attempts have been made to organize foster-home care for convalescent children, but such homes are probably going to be required in the future even when a convalescent home is available.

At a meeting of the rheumatic-fever committee it was agreed that efforts should be made to obtain the consultation services of representatives of the Children's Bureau in planning a rheumatic-fever program, especially with regard to facilities for convalescent care. It was thought best, however, to wait until local efforts could take care of the obvious fundamental steps in improving the clinic's service before asking for consultation. Meanwhile the Children's Bureau has been kept advised of the rheumatic-fever problem in Memphis and the steps that have been taken to solve it, and consultants from the Bureau are planning to come to Memphis in the near future.

It is hoped that the Memphis program will become the start of a State rheumatic-fever program, with special funds for this purpose under the Social Security Act; such programs are now being carried out in about half the States. These special funds are appropriated for grants-in-aid to States for services to crippled children. The services are administered by official State agencies, and the Children's Bureau of the Federal Security Agency administers the grants-in-aid.

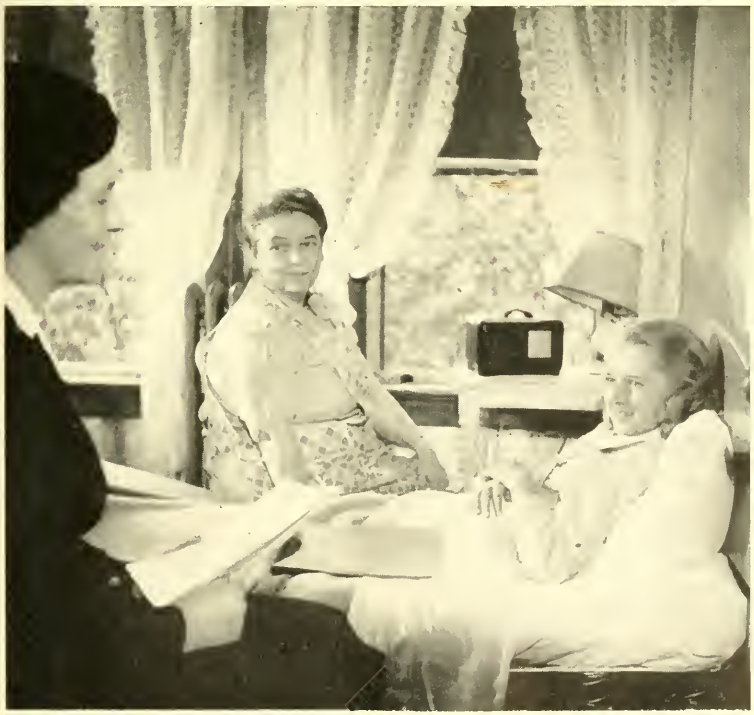
The problems of the education and rehabilitation of children with rheumatic fever, of helping them to prepare to gain a livelihood, are also to be met. But these needs must await the more fundamental one of proper medical care, which should come first, and which is still not adequate.

In the city's efforts to attack its rheumatic-fever problem, as with its other child-health problems, the health steering committee of the community council, the College of Medicine of the University of Tennessee, the Memphis and Shelby County Public Health Department, and private agencies have all shared in one way or another in planning to give the chronically handicapped child his chance for recovery, or at least, improvement.

Particularly valuable have been the contributions of private organizations, especially the junior department of the Nineteenth Century Club, the Junior League, Le Bonheur, Les Passes, the Council of Jewish Women, and the Society for Crippled Children and Disabled Adults.

One of the finest things that comes out of such joint participation in health projects by various groups is the tradition of service which is established and the increasing tendency of additional organizations to make contributions in service and funds for new projects.

This little rheumatic-fever patient is receiving special long-time care at home after leaving the hospital. If the home is not suitable for such care, a convalescent home may be needed.



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To marry and found a family is one of the equal and inalienable rights of all human beings.

UNIVERSAL DECLARATION OF HUMAN RIGHTS

PREAMBLE

WHEREAS recognition of the inherent dignity and of the equal and inalienable rights of all members of the human family is the foundation of freedom, justice, and peace in the world;

Whereas disregard and contempt for human rights have resulted in barbarous acts which have outraged the conscience of mankind, and the advent of a world in which human beings shall enjoy freedom of speech and belief and freedom from fear and want has been proclaimed as the highest aspiration of the common people;

Whereas it is essential, if man is not to be compelled to have recourse, as a last resort, to rebellion against tyranny and oppression, that human rights should be protected by the rule of law;

Whereas it is essential to promote the development of friendly relations between nations;

Whereas the peoples of the United Nations have in the Charter reaffirmed their faith in fundamental human rights, in the dignity and worth of the human person, and in the equal rights of men and women, and have determined to promote social progress and better standards of life in larger freedom;

Whereas the member states have pledged themselves to achieve, in cooperation with the United Nations, the promotion of universal respect for and observance of human rights and fundamental freedoms;

Whereas a common understanding of these rights and freedoms is of the greatest importance for the full realization of this pledge;

Now, therefore, the general assembly proclaims this Universal Declaration of Human Rights as a common standard of achievement for all peoples and all nations, to the end that every individual and every organ of society, keeping this declaration constantly in mind, shall strive by teaching and education to promote respect for these rights and freedoms and by progressive measures, national and international, to secure their universal and effective recognition and observance, both among the peoples of member states themselves and among the peoples of territories under their jurisdiction.

Approved by the United Nations General Assembly, at Paris, December 10, 1948.

Article 1

All human beings are born free and equal, in dignity and rights. They are endowed with reason and conscience, and should act toward one another in a spirit of brotherhood.

Article 2

1. Everyone is entitled to all the rights and freedoms set forth in this declaration, without distinction of any kind, such as race, color, sex, language, religion, political or other opinion, national or social origin, property, birth, or other status.

2. Furthermore, no distinction shall be made on the basis of the political, jurisdictional, or international status of the country or territory to which a person belongs, whether it be independent, trust, non-self-governing or under any other limitation of sovereignty.

Article 3

Everyone has the right to life, liberty, and the security of person.

Article 4

No one shall be held in slavery or servitude; slavery and the slave trade shall be prohibited in all their forms.

Article 5

No one shall be subjected to torture or to cruel, inhuman, or degrading treatment or punishment.

Article 6

Everyone has the right to recognition everywhere as a person before the law.

Article 7

All are equal before the law and are entitled without any discrimination to equal protection of the law. All are entitled to equal protection against any

discrimination in violation of this declaration and against any incitement to such discrimination.

Article 8

Everyone has the right to an effective remedy by the competent national tribunals for acts violating the fundamental rights granted him by the Constitution or by law.

Article 9

No one shall be subjected to arbitrary arrest, detention, or exile.

Article 10

Everyone is entitled in full equality to a fair and public hearing by an independent and impartial tribunal, in the determination of his rights and obligations and of any criminal charge against him.

Article 11

1. Everyone charged with a penal offense has the right to be presumed innocent until proved guilty according to law in a public trial at which he has had all the guarantees necessary for his defense.

2. No one shall be held guilty of any penal offense on account of any act or omission which did not constitute a penal offense, under national or international law, at the time when it was committed. Nor shall a heavier penalty be imposed than the one that was applicable at the time the penal offense was committed.

Article 12

No one shall be subjected to arbitrary interference with his privacy, family, home, or correspondence, nor to attacks upon his honor and reputation. Everyone has the right to the protection of the law against such interference or attacks.

Article 13

1. Everyone has the right to freedom of movement and residence within the borders of each state.

2. Everyone has the right to leave any country, including his own, and to return to his country.

Article 14

1. Everyone has the right to seek and to enjoy in other countries asylum from persecution.

2. This right may not be invoked in the case of prosecutions genuinely arising from nonpolitical crimes or from acts contrary to the purposes and principles of the United Nations.

Article 15

1. Everyone has the right to a nationality.

2. No one shall be arbitrarily deprived of his nationality nor denied the right to change his nationality.

Article 16

1. Men and women of full age, without any limitation due to race, nationality, or religion, have the right to marry and to found a family. They are entitled to equal rights as to marriage, during marriage and at its dissolution.

2. Marriage shall be entered into only with the free and full consent of the intending spouses.

3. The family is the natural and fundamental group unit of society and is entitled to protection by society and the state.

Article 17

1. Everyone has the right to own property alone as well as in association with others.

2. No one shall be arbitrarily deprived of his property.

Article 18

Everyone has the right to freedom of thought, conscience, and religion; this right includes freedom to change his religion or belief, and freedom, either alone or in community with others and in public or private, to manifest his religion or belief in teaching, practice, worship, and observance.

Article 19

Everyone has the right to freedom of opinion and expression; this right includes freedom to hold opinions without interference and to seek, receive, and impart information and ideas through any media and regardless of frontiers.

Article 20

1. Everyone has the right to freedom of peaceful assembly and association.

2. No one may be compelled to belong to an association.

Article 21

1. Everyone has the right to take part in the government of his country, directly or through freely chosen representatives.

2. Everyone has the right of equal access to public service in his country.

3. The will of the people shall be the basis of the authority of government; this will shall be expressed in periodic and genuine elections which shall be by universal and equal suffrage and shall be held by secret vote or by equivalent free voting procedures.

Article 22

Everyone, as a member of society, has the right to social security and is entitled to the realization, through national effort and international cooperation and in accordance with the organization and resources of each State, of the economic, social, and cultural rights indispensable for his dignity and the free development of his personality.

Article 23

1. Everyone has the right to work, to free choice of employment, to just and favorable conditions of work, and to protection against unemployment.

2. Everyone, without discrimination, has the right to equal pay for equal work.

3. Everyone who works has the right to just and favorable remuneration, insuring for himself and his family an existence worthy of human dignity, and supplemented, if necessary, by other means of social protection.

4. Everyone has the right to form and to join trade unions for the protection of his interests.

Article 24

Everyone has the right to rest and leisure, including reasonable limitation of working hours and periodic holidays with pay.

Article 25

1. Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing, and medical care, and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age, or other lack of livelihood in circumstances beyond his control.

2. Motherhood and childhood are entitled to special care and assistance. All children, whether born in or out of wedlock, shall enjoy the same social protection.

Article 26

1. Everyone has the right to education. Education shall be free, at least in

the elementary and fundamental stages. Elementary education shall be compulsory. Technical and professional education shall be made generally available, and higher education shall be equally accessible on the basis of merit.

2. Education shall be directed to the full development of the human personality and to the strengthening of respect for human rights and fundamental freedoms. It shall promote understanding, tolerance, and friendship among all nations, racial or religious groups, and shall further the activities of the United Nations for the maintenance of peace.

3. Parents have a prior right to choose the kind of education that shall be given to their children.

Article 27

1. Everyone has the right freely to participate in the cultural life of the community, to enjoy the arts, and to share in scientific advancement and its benefits.

2. Everyone has the right to the protection of the moral and material interests resulting from any scientific, literary, or artistic production of which he is the author.

Article 28

Everyone is entitled to a social and international order in which the rights and freedoms set forth in this declaration can be fully realized.

Article 29

1. Everyone has duties to the community in which alone the free and full development of his personality is possible.

2. In the exercise of his rights and freedoms, everyone shall be subject only to such limitations as are determined by law solely for the purpose of securing due recognition and respect for the rights and freedoms of others and of meeting the just requirements of morality, public order, and the general welfare in a democratic society.

3. These rights and freedoms may in no case be exercised contrary to the purposes and principles of the United Nations.

Article 30

Nothing in this declaration may be interpreted as implying for any states, groups, or persons, any right to engage in any activity or to perform any act aimed at the destruction of any of the rights and freedoms set forth herein.

World Understanding

(*Continued from page 132*)

the administration of child-feeding, medical, and other projects, without discrimination because of race, creed, or political belief. To millions of children and their families the United Nations, through the Fund, means tangible concern for their welfare.

We learn from social science

Social case work, psychology, and psychiatry have helped us to become objective and nonjudgmental in considering individual behavior. A basic concept underlying these specialities is that "all behavior" is purposeful, and has meaning to the individual, and that only as it is understood and as the conditions underlying antisocial behavior are modified can socially desirable results be achieved.

Cultural anthropologists, social psychologists, and sociologists are giving us insights into different cultures and cultural patterns, and are viewing them in the same objective way that the case worker considers a client.

We cannot deal intelligently with intercultural and international problems unless the beliefs, customs, aspirations, and problems of the peoples involved are understood and evaluated, first by social scientists, and then, so far as possible, by our own public.

During the first and second World Wars, experts in mental health made a tremendous contribution to the success of our armed forces. Social scientists participated in a number of key spots in our war and postwar efforts related to World War II.

Our foreign service now includes not only experts in economics and trade, but also cultural attaches, public health attaches, and, in some of our foreign missions, labor attaches equipped to follow, and give information on, labor movements and labor conditions. The newest comers in our foreign service are two social-welfare attaches, one in Paris and one just assigned to New Delhi.

To develop understanding between peoples

On the whole, recognition of the social aspects of foreign policy and foreign relations has lagged far behind recognition of the political and economic aspects. Attention to social as well as economic factors is essential, if economic goals are to be reached under the Marshall plan, for example; if military occupation is to prepare populations for self-government; if understanding between peoples is to be developed in the degree necessary for sound international relations.

We should study children of other lands

I believe that social scientists, including social workers, have a great contribution to make to foreign policy, and that general provision should be made for their service in the foreign missions of our Nation. An important contribution they can make would be to advance our understanding of the influences and conditions molding the personalities, beliefs, and social behavior of the children of other lands.

One of the greatest needs of each human being is to feel that he is understood. We can greatly promote a feeling of security in other peoples with relation to ourselves if they feel we understand and appreciate their needs, aspirations, and problems. The period of armed truce can be greatly shortened in the direction of permanent peace if we can have greater human understanding among the peoples of the world.

Persuasion, not coercion

The philosopher, Alfred North Whitehead, in his book, Adventures of Ideas, refers to "Plato's publication of his final conviction, towards the end of his life, that the divine element in the world is to be conceived as a persuasive agency and not as a coercive agency." "This doctrine," Whitehead says, "should be looked upon as one of the greatest intellectual discoveries in the history of religion." It is exemplified in the Christian tradition. In organized society there must be sanctions, and in the absence of other means such sanctions have led to war, but the free society can have no final survival or success unless the method of persuasion is its primary instrument.

Social case work applies this principle to the individual. Social work, with psychology and education and the social sciences generally, can help to enlarge the application of this principle in intergroup and international affairs.

Reprints available in about 4 weeks

• FOR YOUR BOOKSHELF

PREMATURE INFANTS; a manual for physicians, by Ethel C. Dunham, M. D. Publication 325, Children's Bureau, Washington, 1948. 401 pp. For sale by the Superintendent of Documents, U. S. Government Printing Office, Washington 25, D. C. $1.25.

Dr. Dunham has stressed in the past that one factor which will help decrease mortality among prematurely born infants is improved education of professional personnel charged with their care. Publication of the book, "Premature Infants; a manual for physicians," is a major step toward this goal.

The text is divided into two sections. Part 1 discusses the physical characteristics and growth of premature infants; the incidence, causes, and prevention of premature birth; mortality statistics; and factors influencing the prognosis for these babies. In part 2, entitled "Clinical Considerations," are discussed clinical appraisal of the premature infant's condition; care in the neonatal period; nutrition; congenital malformations; birth injuries; infections; abnormal blood conditions; metabolic and nutritional disturbances; and miscellaneous conditions such as retrolental fibroplasia and diarrhea.

Excellent summaries for quick use are available at the end of each chapter.

The book has 31 illustrations, and there are 110 references to the literature for part 1 and 414 for part 2. There is also a series of appendixes, which include, among other subjects, specifications for incubators; sample forms for medical and nursing records; description of catheter feeding, or gavage; information on various fluids used for parenteral administration; and a suggested tabulation form for reporting deaths of premature infants in a hospital.

The text is concise and comprehensive, and the book is well printed on good paper. The low price of $1.25, made possible by its publication as a Children's Bureau report, will make it readily available to medical students and to pediatric and obstetric residents, as well as to pediatricians, obstetricians, and general practitioners.

On the back of the title page the author gives the following quotation from J. W. Ballantyne: "In writing the book I have honestly tried to avoid the four grounds of human ignorance set forth so long ago by Roger Bacon: Trust in inadequate authority, the force of custom, the opinion of the inexperienced crowd, and the hiding of one's own ignorance with the parading of a superficial wisdom." One of the chief virtues of the book is the successful effort to meet all these standards by extensive presentation of the sources of support for the opinions expressed.

The American Academy of Pediatrics Committee on Fetus and Newborn recently dedicated its Standards and Recommendations for Hospital Care of Newborn Infants to Dr. Dunham in recognition of her outstanding services in reducing neonatal mortality. This book is one more of her great contributions.

Harry H. Gordon, M. D.

• IN THE NEWS

India Holds Its First Child-Welfare Exhibition

A child-welfare exhibition, presenting some aspects of children's problems all over the world, will begin in New Delhi, India, April 18. The first of its kind in India, the exhibition will be held under the auspices of the Indian National Committee of the United Nations Appeal for Children. Invitations have been sent to all foreign countries and to Provincial and State governments in India.

UNESCO Issues National Commissions Newsletter

Thirty-one of UNESCO's 44 member nations now have national commissions for UNESCO, according to the second issue of the National Commissions Newsletter, dated October 1948. This newsletter was established in accordance with a resolution of the general conference of UNESCO at its second session, in 1947: "That a periodical newsletter be prepared by the Secretariat, including all available information on national cooperative machinery in member states, for distribution to member states, national commissions, and other interested circles."

The plan for establishment of these commissions in the various countries originated in the constitution of UNESCO, which says:

"Each member state shall make such arrangements as suit its particular conditions for the purpose of associating its principal bodies interested in educational, scientific, and cultural matters with the work of the Organization, preferably by the formation of a national commission broadly representative of the Government and such bodies."

The law establishing the United States National Commission for UNESCO was passed in 1946.

• CALENDAR

Mar. 31–Apr. 2—Second National Conference on UNESCO. Cleveland, Ohio. Called by U. S. National Commission for UNESCO.

Apr. 1–2—Directing Council of the American International Institute for the Protection of Childhood. Annual meeting. Montevideo, Uruguay.

Apr. 3–10—National Negro Health Week. Thirty-fifth observance. For information: National Negro Health Week Committee, Federal Security Agency, Public Health Service, Washington 25, D. C.

Apr. 4–6—American Orthopsychiatric Association. Annual meeting. Chicago, Ill.

Apr. 8–9—American Academy of Political and Social Science. Annual meeting. Philadelphia, Pa.

Apr. 18–21—Council of Guidance and Personnel Associations. Annual national convention. Chicago, Ill.

Apr. 18–22—Association for Childhood Education. Salt Lake City, Utah.

Apr. 25–27—National Council of Juvenile Court Judges. Annual meeting. Miami, Fla.

Apr. 25–30—General Federation of Women's Clubs. Hollywood, Fla.

Apr. 30–May 7—National Boys and Girls Week. Twenty-ninth annual observance. Further information from the National Boys and Girls Week Committee, 35 East Wacker Drive, Chicago 1, Ill.

May 15–18—Fourth National Conference on Citizenship. New York, N. Y. Auspices of the National Education Association and the United States Department of Justice.

Regional conferences, Child Welfare League of America

Apr. 7–9—Eastern Regional Conference. Atlantic City, N. J.

May 1–4—Midwest Regional Conference. Chicago, Ill.

June 6–7—New England Regional Conference. Portsmouth, N. H.

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Page 140, Federal Security Agency photograph.

HOW ONE COMMUNITY FIGHTS RHEUMATIC FEVER

In this issue of *The Child*, Dr. James G. Hughes, of the University of Tennessee, tells us what his community, Memphis, is doing about the problem of rheumatic fever and heart disease in children.

As part of the community's broad plan for public health, a rheumatic-fever committee was formed, a committee of wide scope, including representatives of both public and private agencies and members of the various professions concerned with health services.

The members of the committee took a long look at the problem, and then decided what was needed in order to give children with rheumatic fever and heart disease the services they should have. They found that the community needed many weapons for an attack on the rheumatic-fever problem—facilities, personnel, funds, coordination of planning. But instead of being floored by the immensity of the task, they considered all the needs, one by one, and made a plan for meeting each.

Some of the needs, they found, could be met at once by use of the resources already available in the community. Some of them could be met in a comparatively short time through a good deal of hard work and expenditure of the workers' time. Others could be met only after long effort and through calling on resources outside the community.

This program for children with rheumatic fever and heart disease is not yet a complete, accomplished fact; but after reading Dr. Hughes' article one has faith that Memphis will reach its goal.

Planning like this, which pools all the resources of a community, public and private, and brings these resources to bear on a specific problem, is the way to get a program into full operation. And planning that keeps its eye on the long-term goal, while at the same time accomplishing specific objectives as they become achievable, is bound to succeed.

All over the United States communities, large and small, are becoming more and more interested in doing something for their children with rheumatic fever and heart disease.

In about half the States the crippled children's services provided under the Social Security Act now include programs for the location, diagnosis, treatment, and rehabilitation of children with rheumatic fever and heart disease, although in a number of these States the services reach only a fraction of the counties in the State. Many additional States are considering ways and means of establishing such programs.

Private agencies, especially the American Heart Association and its local affiliates and chapters, are energetically mobilizing the interest of professional workers and the public in obtaining services for people with heart disease, including children with rheumatic fever and heart disease.

The Children's Bureau Technical Advisory Committee on Programs for the Care of Children With Rheumatic Fever and Heart Disease—a newly appointed committee—at its meeting March 4 and 5, 1949, discussed at length the unmet needs of such children in our country.

The committee emphasized again and again that coordinated planning is essential. It called for planning in which each of the professions concerned with health services—medicine, nursing, social work, nutrition—contributes what it is best equipped to do; for planning in which public and private agencies contribute what each of them is best equipped to do; coordinated planning, to the end that each individual child gets the kinds and amounts of services he needs, without gaps, duplication, or confusion.

Edwin F. Daily

EDWIN F. DAILY, M. D.
Director, Division of Health Services

VOL. 13, No. 9 MARCH 1949

the CHILD

published monthly by the
Division of Reports
CHILDREN'S BUREAU
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SOCIAL SECURITY ADMINISTRATION
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CHILDREN'S BUREAU
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Publication of THE CHILD, monthly bulletin, was authorized by the Bureau of the Budget, May 12, 1926, to meet the needs of agencies working with or for children. The Children's Bureau does not necessarily assume responsibility for the statements or opinions of contributors not connected with the Bureau. THE CHILD is sent free, on request, to public officials and libraries. For others, the subscription price is $1 a year. Single copies, 10 cents. Send remittance to the Superintendent of Documents, Government Printing Office, Washington 25, D. C.

U. S. GOVERNMENT PRINTING OFFICE: 1949

APRIL • 1949

the CHILD

FOR THE WORLD'S CHILDREN

The United Nations Children's Fund at Work

RUTH CRAWFORD

Information Section, United Nations International Children's Emergency Fund, New York

THE United Nations International Children's Emergency Fund—UNICEF as it is now called round the world—is in its second year of operation.

Each day, with the help of UNICEF, a nourishing meal is placed "on the table" for some 4,000,000 children and nursing and pregnant women in Europe alone, an additional 350,000 children and mothers among the Arab and Jewish refugees in Palestine, and some 200,000 children in China.

Each day thousands of children are tested and vaccinated against tuberculosis—a work now going on in a number of European countries and about to get under way on a large scale elsewhere in Europe, and in North Africa, the Middle East, the Far East, and the Americas.

What the Fund is doing

The feeding program and the antituberculosis vaccination program are the outstanding accomplishments of the Fund to date, but much else is also being done. With the help of UNICEF thousands of children are being outfitted with new clothes—underwear, dresses, shirts and pants, and jackets—and thousands are being fitted with new shoes. Layettes are being provided for the newborn, and diapers are being distributed, 10 to a baby. Thousands of blankets have been rushed to the children in the refugee camps in Greece and in the Palestine area. Supplies have been sent in large quantities to fight epidemics and to start child-health programs. And, not the least important in the long view, several hundred child health and welfare specialists have been given intensive training opportunities.

To make the accounting in still other terms, the Fund's help is going, or soon will be going, to children and mothers in some 30 countries and 6 territories, and to the Palestine area. Governments of 27 countries have contributed money, supplies, or services to the equivalent of more than $75,000,000; and the peoples of 41 countries and 30 territories, through the United Nations Appeal for Children, have raised more than $30,000,000 for the children, of which the equivalent of more than $10,000,000 has been given to the Fund. And from the residual assets of the United Nations Relief and Rehabilitation Administration the Fund has received more than $30,000,000.

Such an international achievement warrants looking into, not only in terms of what has been done, but of how it was accomplished.

Origins of the Children's Fund

The Children's Fund was brought into being out of need. It was as simple as that, and as imperative. UNRRA, after the war, had met part of that need, but UNRRA in 1946 was ceasing operations. The children who had been dependent upon UNRRA for the food that held flesh and bone together could not be left to hunger, and many of them might have gone very hungry if it had not been for this aid.

The General Assembly of the United Nations, acting on the recommendation of UNRRA, established the Children's Fund December 11, 1946. The resolution, No. 57 (I), was passed unanimously; and, happily, that unanimity has been maintained ever since.

The Assembly's resolution established

priorities among the children to be aided, and outlined the methods of operation. It also set forth the principle that aid was to be given strictly on the basis of need, without regard to race, creed, nationality, or political belief. On that basis the Fund has crossed international borders; and, what is no less important, it has started a two-way operation: Almost all of the countries that have received the Fund's aid for their children are now contributing to UNICEF, and their help is given on exactly the same basis as the help of other countries was earlier received.

Make-up of the Executive Board

The decision as to which children shall be aided, and in what way, is made by the Fund's Executive Board. The Board is made up of representatives of 26 nations, broadly representative, geographically speaking, of the United Nations itself. Each of the delegates is appointed by his government. The United States is represented by the Chief of the Children's Bureau. The chairman of the Board is Dr. Ludwik Rajchman, the Polish representative, a man of long experience in the health work of the League of Nations. The chairman of the Board's 10-nation Program Committee is Mrs. Donald B. Sinclair of Canada, who has likewise had a distinguished career in the social welfare field. An American, Maurice Pate, is the Fund's executive director, and assisting him is a small international staff at headquarters in New York and in countries where the Fund is operating.

The actual operation is carried on, through governments and through voluntary agencies within the assisted countries, to reach the children in schools, clinics and hospitals, children's centers and institutions, and the like. The vastness of the operation, the many kinds of aid offered, the Fund's relation to both donor and recipient governments, and the many other complexities must lead to the question as to how such a work has been possible in so short a time in the midst of today's political strife and economic uncertainties. The answer, perhaps, is that the Fund had to succeed. It could not be allowed to fail.

The Fund's operation

The Fund, in starting its work, had behind it the experience of UNRRA. Equally important, it had the sum of knowledge and experience represented by the Executive Board, supplemented by expert opinion drawn in from time to time.

Because of that pooling of experience, the Fund's program in any country, in both its broad outlines and its detail, has many points of similarity with what is being done elsewhere in the world.

The basic principle of the Children's Fund operation is this: It draws upon countries and peoples that are able to contribute in money, goods, and services, and then distributes that aid, country by country, on the basis of children's needs, in ways that help those countries build up their own services.

The Fund's aid is given conditionally, with the recipient being required to meet certain conditions, among them to carry part of the cost. The UNICEF contribution must be matched by the recipient government: In practice, it is often more than matched; in some instances the Fund's contribution is but a small part of the total cost. Thus the aid offered serves as a stimulus to local endeavor.

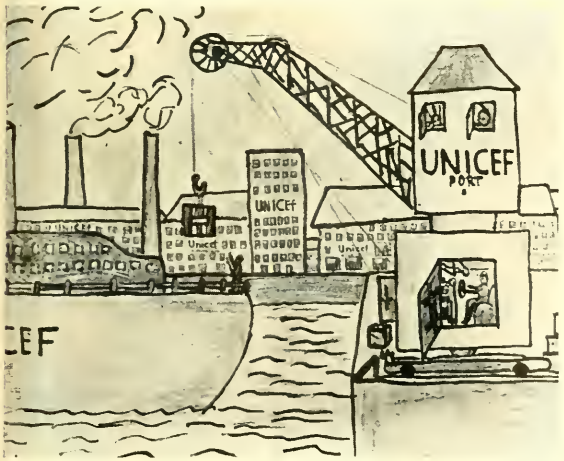
Throughout the operation the Fund's role is that of trustee between donor and recipient. That trusteeship is respected and shared, in turn, by all who are participating in the program, through to those who make the final entry in the kitchen storeroom books. In carrying out this trust the Fund acts upon the evidence—the bill of particulars about children's needs. Before undertaking any program, studies are made by experts, and the facts are brought before the Program Committee first, and then the Executive Board.

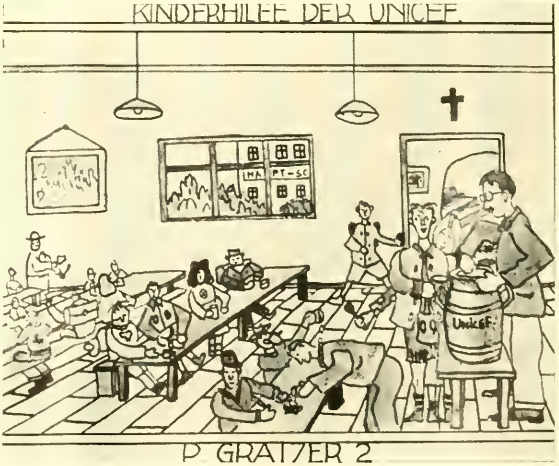
A plan of operations is then drawn for each country, in cooperation with officials of that country. That plan, in effect, serves as a contract.

The aid reaches the children

Then begins the actual work of getting aid to the children. Difficulties are many, particularly in these days of short commodity supplies and currency difficulties. The Fund, in effect, takes its

Europe's children say "Thank you" to UNICEF in their own way. These two drawings, and the one on page 149, were exhibited in Vienna, along with 2,000 other drawings and designs, as part of a poster contest that was held for children in Austrian and Czechoslovak schools.





shopping list—milk, meats, fats, and fish-liver oils; medical supplies; raw materials—to the world market, with its hard and soft currencies, and shops to advantage to get the most for the money. At the receiving end, the mission and the responsible government agencies take over, and supplies are moved to where the children are waiting. Every kind of conveyance is used, including oxcarts that get through the mud roads to the villages, and airplanes that fly BCG vaccines, and, on occasion, emergency supplies of food, medicine, and blankets.

Some must go without

Fortunately there is good will all around, and somehow the supplies get to the proper warehouses on time and in good order. They are then drawn upon, as planned, for certain categories of children in specified places. At that level, the greatest difficulty of all often has to be faced; that is, making a choice between one child and another as to which one may have the Fund's aid, since there is not enough to go around.

The choice is made in various ways: Commonly it is on the basis of a doctor's recommendation or that of a social agency. Parent-teachers committees provide further means of selection and control. Sometimes the choice may be between the child whose father is unemployed and the one whose father is temporarily employed at a small wage. Such choices are made day after day, with all who have any part in it rebellious, yet carrying through the assignment. Is it not better that at least some be fed?

"From the United Nations"

The brighter side of the picture is bright indeed, for it is the reality of the United Nations itself. The fact so generally lost sight of is that in this warring world many children are being helped back to health and strength by the United Nations. One can imagine the thoughts of a mother as she reads the wrapper around the diapers given her for her baby: "From *the United Nations*"; the joy of a little girl who for the first time in her life has a new dress, a shirt, and panties, from the United Nations; the boy with his new pair of shoes; the refugee boy or girl with a warm blanket; to say nothing of the 4,000,000 or more who have been fed a supplementary meal each day with the help of the United Nations. What must the thoughts be of parents who come from miles around to bring their children to be vaccinated against tuberculosis? The United Nations helped make that possible.

Gratitude, though, is a word one should be careful about using when speaking of a generation of children who have suffered as these have suffered because of war, yet gratitude—and pride—are the words. The children write "thank you" letters to the United Nations; they draw pictures of the United Nations, pictures that show they have caught hold of the idea that the United Nations is *all* people, working together. Their teachers write, and their parents, and the town officials, and others who have seen what has been accomplished.

And their pride! This they will do for the United Nations *as the United Nations wants it done!* At the government level that pride is expressed in the instructions to the staff. Particular emphasis is invariably given to the stipulation that the aid must be given without discrimination.

What is taking place in the towns and villages where UNICEF is operating can perhaps best be likened to what happened in this country during the war, under the Emergency Maternity and Infant Care program.

The law was written that made good care possible for servicemen's wives and infants, but before they could get that care, hospitals in many communities had to be brought up to minimum standards. One thinks of the miners in a town in Wyoming who on their days off cleaned, painted, and put in order a place that could be used for a hospital.

In a town in Bulgaria the people converted a saloon into a children's center, where UNICEF could operate. They cut down the tables and chairs to children's size, made cupboard space behind the bar, and painted the place brightly. They left the horseshoe over the door, for luck.

In Italy, milk bars have been opened by volunteer groups so that UNICEF milk can be distributed to preschool-age children.

Thousands of volunteers take part

In China, often it is the missionary group that carries on; one missionary made her way through the military lines to get UNICEF supplies.

The examples are as many as there are towns and villages, for the UNICEF operation, when it finally gets to the children, is one carried on in large part by volunteers. They trudge to the schools through all kinds of weather early in the morning, to prepare and heat the milk so that it will be ready when the children arrive. They find corners where a stove and a table and chairs can be set up, and the children brought in out of the cold. They find the stove, and the firewood, and the pots and pans and ladles. And, from their

Vaccination of children against tuberculosis with BCG vaccine, an international program now conducted as a joint enterprise by UNICEF, WHO, the Scandinavian Red Cross, and the governments of the assisted countries, will soon be taken over entirely by those governments.

own small stocks, as well as from national government supplies, they supply bread and vegetables and fruits to "match" UNICEF supplies. These volunteers are numbered by the thousands—in Europe alone there are more than 40,000 feeding centers, most of them using volunteers.

And, as everywhere, one gain leads to another, with much that will some day be traced back to UNICEF. The habit of milk drinking, for instance.

The Fund's feeding program is based on milk—mainly dried skim milk. It has the proteins the children need; it is cheap, comparatively; and it can be easily handled, and it is sanitary. In many places, though, it was a strange product; for that matter, many children were not accustomed to milk in any form. In order for it to be accepted, its value had to be explained, just as in this country, a generation ago, the importance of a safe supply of milk had to be taught to mothers. Now in all the UNICEF countries where child feeding is being carried on extensively it is widely accepted. In fact, UNICEF milk has been so well "sold" that in some places a counter-campaign has had to be undertaken to persuade mothers that their own milk is best for their infants. For the older groups the results are so apparent in the children's improved health that all are convinced.

The question remaining is how can the children continue to have milk when UNICEF is no longer in operation. Already important steps have been taken by the UNICEF-assisted countries to assure a continuous supply. With UNICEF's help they are building their own milk-processing plants. UNICEF is supplying only certain patented parts; the rest of the equipment, the buildings, and the labor are being supplied by the recipient countries. The product is to be distributed free to needy children.

In the same way, other programs now being carried on with UNICEF's aid are destined to have a lasting effect on the health and welfare of children. The BCG antituberculosis vaccination program, now being conducted as a joint enterprise by UNICEF, the Scandinavian Red Cross societies, and the governments of the assisted countries, will soon be taken over in its entirety by those governments. They will have their own sources of vaccine, and their own corps of technicians. They will take over, too, the full responsibility for venereal-disease eradication programs and, in time, the malaria-control and other programs initiated with the help of UNICEF. (The Fund's medical programs are carried on in cooperation with the World Health Organization and under policies developed by a joint UNICEF-WHO Committee on Health Policy.)

Meanwhile, the Fund's help is being used in still another way likely to have effect not only in the assisted countries but in the whole field of child welfare.

To help develop national programs

Last summer, as part of their contribution to the Fund, the governments of France, Sweden, and Switzerland arranged special courses which brought together those who are carrying, or who are expected to carry, heavy responsibility for developing national child-health and child-welfare programs.

The Swiss course was designed especially for those dealing with child victims of the war; the one in Sweden was for doctors. The French course was the first of its kind anywhere, for it brought together a faculty of outstanding authorities in the whole field of social pediatrics.

These courses were so successful that courses are again being organized—this year also in England—and this phase of the Fund's work is due to be expanded, particularly as work gets further along in the Far East. There, the first need is for trained personnel, for without them the best-laid plans must remain on paper.

Programs vary with needs

In meeting the needs of children, the Fund has been flexible, suiting its operations to the special needs of the various countries.

In Europe the basic program has been one of child feeding.

In the Middle East, too, material aid has likewise been dispatched.

In the Far East, however, programs of another kind are being developed in order to make the Fund's help count most effectively.

In China, for one example, an American surgeon, Dr. Leo Eloesser of San Francisco, has worked out with the Chinese a training program that may be the means of bringing basic health knowledge to large sections of the population. With the Fund's help he proposes to train cadres of workers—people of ordinary education—who will in turn train others in an ever-expanding circle.

Teaching maternal and child health

What Dr. Eloesser is doing in China may very well be adapted to other areas in the Far East, and elsewhere, where the people do not yet know the elementary rules of sanitation, disease prevention, and maternal and child care.

At the same time, the Fund's assistance is being asked by a number of American countries for special demonstration projects to show the way to improved health for mothers and children. In all these undertakings the Fund is working closely with the World Health Organization, the Food and Agriculture Organization, and other United Nations organizations.

What can be done, though, still remains small in relation to the world's great need, for the Fund's resources are extremely limited.

The money the Fund has so far received has been spent, or allocated, for present programs. It is hoping that more money will be forthcoming from governments—its mainstay—and from the second United Nations Appeal on

(Continued on page 158)

TO COMBAT CEREBRAL PALSY

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CEREBRAL PALSY is a physical handicap caused by some disorder of those parts of the brain which control muscular activity. In terms of this definition, cerebral palsy, except to the highly specialized diagnostician, is not a clear-cut disease entity like rheumatic fever or infantile paralysis. We can describe it though and can generalize regarding cerebral palsy in several respects and so come closer to understanding the condition.

No one cause known

First, as to the cause. This condition may be the result of any of a variety of causes. Brain changes may occur during pregnancy through illness of the mother and thus of the unborn infant; or during pregnancy through maldevelopment of the brain. Similar changes may occur in the brain at the time of birth. These so-called birth injuries once were thought to account for 80 to 90 percent of all cases of cerebral palsy. It is now believed by qualified authorities that a closer estimate would be in the neightborhood of 10 percent. Lastly, disease of the infant or child, such as brain fever or meningitis, or head injuries, such as skull fractures, can lead to the damaging type of brain injury.

Range of intelligence wide

We can also generalize regarding the outlook for these children. Experienced medical observers have estimated that at least two-thirds of them are educable, with I. Q.'s showing the same range as unselected children—that is, from slightly retarded to superior intelligence. This is a marked contrast to the evaluation of these children by the general public and, unfortunately, by many educators and physicians.

Another generalization that can be made is in respect to the clinical picture. In this connection several points deserve emphasis:

1. There is considerable variation in the type of muscular involvement, but two main types do make up the majority of cases. These are the spastics, or those with stiff muscles; and the athetoid, or those with involuntary movements.

2. Clinically, there is also considerable variation in the degree of severity, all the way from complete incapacity to very minor involvement, practically unnoticeable.

3. Another important clinical observation is the frequency with which other handicaps, also due to brain abnormality, accompany the muscular dysfunction. Some of these children are blind; some have severe cross eye; some are deaf; some have specific reading or speech disabilities; some definitely do have severe mental deficiency; others have definite personality and emotional difficulties. In this latter group it is sometimes difficult to decide how much of the handicap is on the basis of brain damage and how much is on the basis of a quite reasonable reaction to their severe physical disability.

Cerebral-palsied child long neglected

So we have a group of children, many of them severely handicapped physically and, by reason of their physical handicap, barred from a normal education and from many of the normal personal and social satisfactions in life.

For many years it was accepted by everyone but a few particularly interested people that nothing could be done to educate and rehabilitate these children.

An educational process

In recent years our interest and subsequently our knowledge has increased. We can now say definitely that for a substantial percentage of the total, adequate care can bring definite improvement. But this care is extremely complicated. Cerebral palsy is not a specific disease with a specific cure. There is no drug or single surgical procedure

Experienced medical observers have estimated that at least two-thirds of the children with cerebral palsy are educable, that their mentalities range from slightly retarded to superior.

Given at meeting of Denver Public Health Council, December 2, 1948, at Denver, Colo.

which will cure the condition. Rehabilitation of these children is to a large extent an educational process both physically and mentally.

From the physical standpoint at least this means a long, tedious, and expensive program of care. It means provision of adequate diagnostic facilities, since without a precise and detailed diagnosis there cannot be adequate planning for treatment. It requires constant reevaluation and replanning of the course of treatment. The treatment program itself involves the services of many skilled persons.

Many facets of care

First, of course, comes the physician trained and experienced in the diagnosis and care of these children. Upon him falls the responsibility of planning, with the other professional persons, what can be done for a specific child.

To assist the physician both in his diagnosis and his planning and evaluation of treatment, it is necessary frequently to have additional medical services such as those of a neurologist, a pediatrician, an orthopedic surgeon, an ear specialist, an eye specialist, or a psychiatrist. Then to a very large extent the further day-to-day care depends on workers in other professions—the physical therapist, the occupational therapist, and also the speech therapist.

But all this is only part of the picture. These children, of course, need the education that any child needs. Initially at least, many of them do not fit into the regular classroom program. Accordingly, it is necessary that teachers especially trained to work with handicapped children be available. Often, to guide the educational process properly, psychological evaluation and assistance is necessary, and obviously special facilities and equipment are often needed.

If you could spend a day in a center designed for the care of these children it would soon become obvious that it is absolutely necessary for all these people to function as a team.

To use a very simple example, it is useless for the speech therapist to work a half hour or an hour with a particular child in the morning, only to have him revert completely to his poor speech habits for the remainder of the day while in the classroom.

We must remember the whole child

All the participants in the treatment team are highly skilled in their particular professions, and all contribute to the total program; but any one of them can give only a partial service.

As a practitioner I have had these children in my office and have been completely baffled as to how to give them anything approaching adequate care in a community with no program for their rehabilitation and education.

There are many physical therapists who can carry along for a while in their special field, but they are always acutely aware of the other skills necessary to rehabilitate the *whole* child. The concept of working with the whole child is important and must never be lost sight of in the plan of care.

For a normal life

We want for these children, as for all children, (1) the best possible health status; (2) the best possible educational attainment; (3) the fullest possible personal and social satisfaction; and (4) the best possible occupational adjustment.

There are, of course, many other weapons for fighting cerebral palsy. Research into the causes, with the ultimate goal of prevention; adequate institutional care for those needing it; as rapid return to a regular school environment as possible; good case-finding procedures; and many other items that we cannot go into now. The working of a complete community program for cerebral palsy and the part played in such a program by personnel of the health department, such as public-health nurses, medical-social workers, nutritionists, and physical therapists, is a complete discussion in itself.

But why are there so few facilities for complete care? What are the obstacles to obtaining these objectives for this particular group of children? Broadly, they are the same obstacles that exist to developing adequate services in many other fields related to the health problems of children.

Trained workers needed

One is the lack of trained professional personnel. It is at the present time almost impossible to go out and employ persons especially trained and experienced in cerebral palsy in any of the professional fields we have mentioned. Even more discouraging is the fact that at the present time the facilities for training persons in this highly specialized field are almost nonexistent. We do hope that through current activities of both voluntary agencies and

(Continued on page 158)

For children with cerebral palsy, as with all children, the principle of working with the whole child is important; and it must never be lost sight of in the plan for the child's care.

TEN YEARS' PROGRESS IN STATE PROTECTION OF CHILD WORKERS

Child-Labor Standards Show Net Gain, 1939–48

LUCY MANNING *Bureau of Labor Standards, U. S. Department of Labor*

A CENTURY has passed since the first law was enacted in this country to protect children from premature employment. In 1848 Pennsylvania passed such a law, prohibiting employment of children under 12 in textile mills. A number of States took similar action during the following decade. These laws did not provide for enforcement, but by enacting them the States recognized the cardinal principle of child-labor legislation—that childhood is a time for growth and schooling.

Since these early attempts to keep young children out of factories, the fight against child labor has made tremendous gains, far outbalancing the losses that have occurred from time to time.

The decade 1939–48, the tenth since Pennsylvania's pioneer legislative action against child labor, was largely a war period—a time when more losses than gains in child-labor standards might have resulted. It was a time when severe labor shortages—both in the defense period and the actual war years—brought about strong demands for young workers. Wartime emergencies were pressuring legislatures toward relaxing child-labor standards and were influencing educational authorities toward weakening school-attendance requirements so that children could enter employment.

Even before the war began, defense activities brought about increased employment of young workers, not only in industries supplying war needs but also in such work as agricultural and domestic service and in restaurants and stores. As the war progressed and the adult labor reserve decreased, the younger worker became more and more in demand, and efforts to break down legal child-labor standards which had begun even in the defense period preceding the war increased.

Before 1943 the acts relaxing standards affected, for the most part, young people 16 and over. A few relaxations permitted temporary release from school of children under 16 for farm work. In 1943 more and more acts were passed relaxing child-labor standards, though most of them applied only to the war period or to the period of hostilities.

Various factors operated to protect young workers during the war, and not the least of these was the recognition in the public mind that child-labor standards built up over the last century should be maintained if possible. This is reflected in the legislative pattern followed in most States of limiting modifications to the war period and setting up administrative safeguards in many of the laws. Another factor was the vigorous work of women's groups and other private organizations, which resulted in the defeat of many bills to lower standards.

A major contributing influence was the positive attitude of the Federal Government toward upholding State and Federal child-labor standards.

In January 1942, for example, the Secretary of Labor issued a statement regarding labor-law relaxations, with the concurrence of the War and Navy Departments. It recognized the need for all-out production, and emphasized the importance of maintenance of working hours which would ensure maximum continued production. It also pointed out that although, during a period of adjustment, hours standards might be relaxed if and when necessary, there must be no relaxation of standards governing employment of children under 16.

Another step by a Federal agency, looking to the maintenance of child-labor standards, was taken when the Chief of the Children's Bureau appointed a General Advisory Committee on the Protection of Young Workers.

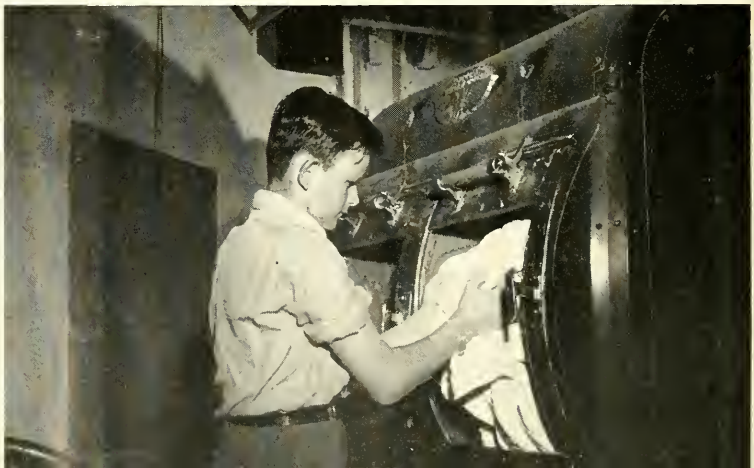
For the same purpose the War Manpower Commission recommended a "Policy on the Employment of Minors Under 18 Years of Age."

Also the Children's Bureau and other interested Federal agencies jointly developed "Recommended Policies for Recruitment of Children for Wartime Agriculture" and "Policies for Part-Time Employment of School Youth."

An important influence was the fact that a number of Federal agencies interested in manpower requirements, including the War and Navy Departments, adopted a policy of adhering to State and Federal child-labor standards.

A strong impetus to, and support for,

Operating a commercial laundry machine is a dangerous job from which minors under 18 should be protected. A number of States have laws setting 18 as the minimum age for such work; a few of these protective child-labor laws were passed during the 10-year period 1939–48.



During 1938–49 school-attendance laws were improved in more than one-fourth of the States.

development of these national policies was found in the child-labor provisions of the Federal Fair Labor Standards Act of 1938, which apply to establishments producing goods for shipment in interstate or foreign commerce.

These provisions had been in effect substantially 3 years when the United States entered the war. They had been favorably accepted by employers and by the public. In general, they set a 16-year minimum age for work in manufacturing, mechanical, and processing occupations; a 16-year minimum age for employment during school hours; and an 18-year minimum for employment in hazardous occupations.

The act permits employment at the age of 14 outside school hours in limited occupations, under special safeguards.

The successful upholding of these Federal provisions during the war, except for temporary minor exceptions, was a major factor in support of State legislation. Any break in the Federal child-labor standards undoubtedly would have spread to State standards.

Improvements made in basic standards

Improvements made by the States enacting child-labor legislation during the decade affected the minimum age for employment, maximum hours of work, work at night, employment-certificate requirements, and employment in hazardous occupations. School-attendance requirements were also materially strengthened, and the status of minors under workmen's compensation laws was improved.

Rise in minimum-age standards

The most outstanding advance during the 10 years 1939–48 was improvement of minimum-age standards, and, particularly, wider adoption of a basic 16-year minimum age for general employment.

At the beginning of the decade, the laws of only 10 States had a basic 16-year minimum age for general employment. At that time the idea of a 16-year minimum age was just beginning to make headway.

Today 20 States and Puerto Rico have a 16-year minimum, either for employment at any time in manufacturing establishments, or for employment in any gainful occupation during school hours except, in some States, in agriculture or domestic service.

Two States—Maine and Texas—have set a 15-year minimum age, Maine having strengthened its 15-year minimum-age requirement in 1945.

Twenty-five States, the District of Columbia, and Hawaii still set a minimum age for employment of only 14.

One State—Wyoming—sets no minimum age, but in that State children required to attend school may not be employed during school hours.

Almost every State that revised its minimum-age standard within the decade established a basic 16-year minimum for general employment. This trend toward 16 as the basic minimum age in State child-labor legislation may well be another indication of the influence of the child-labor provisions of the Fair Labor Standards Act on State child-labor legislation.

More States set a maximum 40-hour week

Since 1939, nine States have recognized the need for controlling the hours of work of boys and girls who go to school and in addition carry a job. Fifteen States, as well as Hawaii and Puerto Rico, now limit hours of employment of children attending school and working outside school hours.

Another important development was that a few States reduced the maximum workweek permitted for minors under 16 or 18 years of age to 40 or 44 hours.

At the beginning of 1939 North Carolina and Rhode Island had a maximum 40-hour workweek for minors under 16; and Wisconsin had a maximum 24-hour week.

During the 1938–49 period 7 States (Alabama, Florida, Georgia, Kentucky, New Jersey, West Virginia, and Virginia) established a 40-hour workweek for children under 16, making a total of 10 States with a maximum 40-hour week. One other State, Louisiana, during this period, changed its former maximum 48-hour week to 44.

There are now 18 States that limit maximum weekly hours of children under 16 years to 44, or 40, or less. A maximum 48-hour week, however, is still the most usual standard for children under 16.

During the 10-year period Kentucky, New Jersey, and Virginia limited the maximum weekly hours of workers 16 and 17 years of age to 40; and Louisiana limited them to 44, making 9 States that now have a maximum week of 40 or 44 hours for boys and girls of these ages. Only about half the States, however, now have any limitation on weekly hours for both boys and girls 16 or 17 years of age.

Little gain in prohibition of night work

The States made little change in the prohibition of night work in 1939–48, either for workers under 16 years of age or for those 16 and 17.

Most States prohibit work for minors under 16 after 6 or 7 p. m. Only 15 States, however, have any protection against night work for both boys and girls 16 and 17 years of age in general employment. In 23 States there is no regulation of night work for either boys or girls of these ages, and in 10 others there is no night-work prohibition for boys of 16 and 17.

Employment-certificate standards strengthened

An employment-certificate system has come to be regarded as fundamental to a good child-labor law in this country and basic to its effective enforcement. The employment certificate, or work permit, if properly issued, safeguards the child by ensuring that he has fulfilled all the legal requirements for the job and helps the employer by providing a means whereby he may be certain that he is complying with the law in hiring the child.

During the 10 years we are reviewing, a number of States, including Georgia, Louisiana, Kentucky, New Jersey, Virginia, and Florida, improved their certificate standards. The first 5 States extended their employment-certificate requirement to include boys and girls 16 and 17 years of age; Florida amended its law to require age certificates for minors of these ages. Maryland and Minnesota specifically provided by law for issuance of age certificates upon request.

At the present time practically all the States require employment certificates or work permits as a condition for the employment of children under 16; and 24 States require employment or age certificates for the employment of minors 16 and 17 years of age.

A few of the States that do not require employment or age certificates for minors above 16 years of age provide by law for issuance of certificates of age to minors 16 and over upon request.

In most of the remaining States such certificates are issued administratively, and since 1939 State employment and age certificates have been accepted by the United States Department of Labor as proof of age under the child-labor provisions of the Federal Fair Labor Standards Act in 44 States. Equally as important as the requirement for employment certificates are the methods of issuing the certificates and the administrative procedures used to ensure uniform and efficient issuance. There is little doubt that acceptance of State certificates as proof of age under the Federal act, through cooperative arrangements between the States and the Department of Labor, has been an important factor in strengthening State certificate procedures.

More States protect children from hazardous jobs

Special protection from employment in hazardous occupations, a need that has long been recognized in child-labor legislation, was materially strengthened in eight jurisdictions.

Kentucky, Louisiana, West Virginia, New Jersey, and Puerto Rico, which, during the decade, set a minimum age of 16 for general employment, also established a minimum age of 18 for a considerable number of specific hazardous occupations.

At the same time, these States, as well as Florida and Hawaii, authorized a State official, usually the commissioner of labor, to declare occupations hazardous for minors under 18.

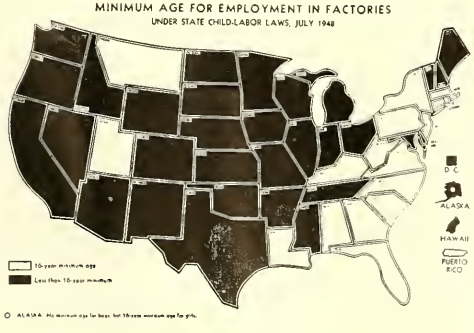
Maine established a minimum age of 18 for employees in any work—in specified establishments—that is determined by the State commissioner of labor and industry to be hazardous, and under this authority many hazardous occupations were closed to young people under 18.

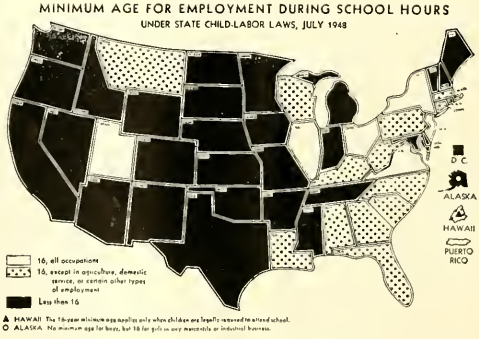
Practically all the States now have prohibited employment of minors in some hazardous occupations, usually setting the minimum age for such work 2 or more years higher than that for general employment. Only about half the States, however, extend any substantial protection from such work to minors 16 and 17 years of age.

Children in agricultural employment neglected

Today, as 10 years ago, regulation of child labor in agriculture remains the weakest link in the chain of child-labor control. Most State child-labor laws do not offer any real protection to child workers in agricultural employment. Employment of children in commercialized agriculture continues, as in the past, to bring to the children long hours of work, lack of educational opportunity, physical hardships, and low living standards.

But within the decade some measures were passed in a number of States, regulating the employment of children in commercialized agriculture; and there has been a resurgence of public interest in the plight of the migrant farm worker, adult and child alike. The standards for agricultural employment included in this recent legislation usually are lower than those set for industrial employment.





Regulation of child labor in agriculture is the weakest link in the chain of child-labor control.

Puerto Rico, in its child-labor act, set the same standards for agricultural work as for other work.

New Jersey, in 1940, established a minimum age of 16 for work in agriculture during school hours, and 12 for such work outside school hours. New Jersey also required certificates for employment of children under 16 in agriculture and limited working hours of such children to 10 a day.

In five other jurisdictions—Connecticut, Florida, Illinois, Virginia, and Hawaii—minimum-age standards were extended to agricultural work, at least for such work during school hours. In Illinois and Virginia a 16-year minimum age now applies to farm work during school hours, and in Florida a 14-year minimum age does the same. In Hawaii a 16-year minimum age applies to such work if the child is required to attend school; if he is not required to attend school, a minimum age of 14 applies.

Connecticut, in 1947, adopted a 14-year minimum age and established a maximum 8-hour day and a 48-hour, 6-day week for children 14 and 15 in farm work. These provisions apply, however, only during those weeks in which the employer's average number of employees is more than 15. The law deviated from the customary pattern of placing administration of child-labor laws in the State labor department by placing the administration of the act in the State department of agriculture.

Workmen's compensation laws improved

In a few States the status of minors under workmen's compensation legislation was improved during the 10 years 1939–48. Mississippi provided for payment of double compensation in case of injury to a minor while illegally employed. New Jersey raised from 16 to 18 the age under which workmen's compensation benefits are doubled in case minors are injured while illegally employed. Three States, Louisiana, Minnesota, and Iowa, brought illegally employed minors within the coverage of their workmen's compensation acts.

Another important development was a Louisiana act establishing a compulsory system of workmen's compensation for minors between 12 and 18 years of age who sell or deliver newspapers or do other specified street work.

States strengthen school-attendance laws

During the 10-year period improvements were made in compulsory school-attendance laws, which are a strong support to child-labor controls, in over one-fourth of the States. These included raising the upper age for required school attendance; eliminating some of the exemptions that weakened the requirements for school attendance; lengthening the required minimum school term; and improving provisions for enforcement of compulsory school attendance laws.

In 1939 there were still 4 States that did not have a 16-year upper age for required school attendance on a Statewide basis: Georgia, Louisiana, and North Carolina required attendance only to 14 and Virginia to 15. Today every State requires attendance to 16 years—some to 17 or 18—although all States permit some exemptions and many release children at 14 if they are employed.

Net result is gain

Along with the modest gains made in the decade, we find some losses. A few child-labor standards were lower in 1948 than in 1939. Not all wartime relaxations were temporary. And some States removed long-standing employment safeguards, usually for minors 16 or over. For instance, the minimum age for work of girls in theaters and other places of amusement in Ohio, and in restaurants in Utah, was reduced from 18 to 16. The minimum age for pinsetting in bowling alleys was lowered in a number of States.

In a few States maximum-hours or night-work standards for minors 16 and over were lowered. The night-work prohibition applying to minors of these ages working in textile factories in Massachusetts, and in factories and certain other establishments in Delaware were weakened. Work in canneries, of boys and girls 16 and over in New Hampshire and Ohio, and of girls 15 and over in Texas, was exempted from hours or night-work standards.

A few of the lowered standards affected even children under 16. Michigan, for example, lowered its basic minimum age for general employment from 15 to 14; New York and Utah adopted exemptions affecting work of children as caddies.

These scattered reductions, however, did not affect the general framework of the laws. Nor, for the most part, did they affect major standards, such as the standards concerning the minimum age for employment or those concerning the requirement for work permits. Again the reductions in standards usually did not apply to children under 16. We can therefore conclude that State child-labor standards weathered the storm well, and that the decade 1939–48 ended with a net gain.

Reprints available in about 4 weeks.

CHILD CARE AND WORLD PEACE

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NATIONAL GROUPS differ from one another in their basic ways of looking at the world. These differences go deeper than merely different descriptive *content* of tribal beliefs; they seem to rest upon subtle but profound differences of *temperament* between group and group. For a long time these temperamental differences were somewhat mystically laid at the door of race: but racially mixed nations were often found to have a fairly uniform temperament in all its members, and peoples of the same race differed widely as they belonged to different tribal or national groups.

Nowadays we can see the true causes of the deep-going psychological differences in character structure of adults in various societies. A group of adults who have grown up in the same society have a least common denominator of similarities in temperament to the extent that they have all grown up under the culturally provided *patterns of bringing up children* in their society. Their basic emotional attitudes toward life will have basic typical characteristics, to the extent that they have all gone through the same pedagogical mill.

Differences are fundamental

These differences in culturally conditioned "national" temperament (character structure for short) are deeper than rationality or logic. They are really of the order of the psychological differences between individuals. Like optimism or pessimism, shyness or expansiveness, trust or suspiciousness, they are beyond change by mere argument, they are fundamental, and they precondition all overt "rational" arguments and attitudes.

The irrational clash of different groups in wars is due to the fact that the groups don't talk the same psychological language: they misunderstand each other because they have basically different expectancies, and demands on life. Accustomed to the implicit agreements and understandings they find in other members of their own group, and failing to find these automatic agreements in outsiders, they consider the outsiders wilfully perverse, systematically stupid, or "just plain crazy." We can get at the rational roots of war with the aid of economics, diplomacy, and so on: but how can we get at these irrational roots of war?

Every society has its own notions of an ideal personality type to aim for, and perhaps its own child-rearing techniques are the real cause of whatever success they do attain. "Maladjusted" individuals will be those who do not fit that culture's preferences, and a society's misfits reflect its specific idealisms. Every tribe has firm ideas about what constitutes the "good" man—but the ideal varies hopelessly from tribe to tribe!

Now since in modern times these blind tribalisms are beginning to impinge catastrophically upon one another, on a greater scale, we ought to begin to think about what we can do ultimately to contain the situation. Part of the solution will be, I think, in terms of "What ought the citizen of one world to be like?"

It is true we have no sound way of choosing among the many tribal voices as to everything that ought to go into the basic character structure of the ideal world citizen. There would be too much cultural subjectivity in any list of traits, if we chose them from the point of view of our own preferences. But we don't have to do such a grandiose and such an arrogant thing. The proportions of the necessity are more modest and clear. Let us see how the world situation itself is such as to help us define what we need by way of the minimally necessary qualities in our world citizens.

Social workers, psychiatrists, and mental hygienists will be quick to see that the anthropologist is here talking their language, and coming to the same conclusions they have come to, but by a different road. The student of culture-and-personality is convinced, as they are, that the world's peace is ultimately tied up with the kinds of human beings that our various cultures produce. Here is some of the anthropologist's concrete thinking.

The stubborn fact is that the world contains many racial and tribal differences. Therefore what we need is a personality that can accept and be tolerant of all kinds of differences among human beings. (Social workers will recognize that I am here talking about their basic professional skill, their ability to relate themselves to people and to handle the relationship. Psychiatrists can easily fit the correct technical terms to this: What we need is less primary narcissism and more mature object relationships.)

Home atmosphere should be democratic

A culture ought not, by its very nature, generate frustrations and aggressions that it cannot handle internally. It seems to me that this implies that we should have a permissive, democratic atmosphere from A to Z in our child care. For it is frustrated individuals who are vicious, and it is individuals that cannot achieve legitimate expression of their aggression within a society who are liable to express the bottled-up aggression on "the enemy" beyond their tribal borders whom they have never seen.

Indeed, a culture that generates such forces could well benefit by having some of this aggression used to modify itself. An absolutist atmosphere does not permit this, but builds up further unexpressed, explosive hostilities. A permissive, democratic atmosphere achieves maximal expression of differences, and drains off aggressions usefully as they arise.

The ideal world citizen will be able to criticize his own system maturely; the best kind of insight is insight into oneself. The world citizen ought not

to be cowed by his cultural superego, or to be awed by the authority of his tribal ancestors. Like the cured neurotic, he ought to be able to talk back to the voice out of the dead past, which may have made misjudgments.

The ideal world citizen will be able to take self-responsibility for his own values. The surest way of gaining such world citizens is to give self-responsibility freely to children as they can increasingly manage it.

We have enough dogmatists and absolutists. But dogmatists are insecure people, whose fanaticism is the measure of their insecurity. We desperately need large numbers of people in the world who can tolerate honest intellectual differences of opinion without resorting to violence when they do not carry the day. This applies to our pedagogues and to all who have to do with the training of children by example. We should as jealously protect children in their rights as persons, as we should jealously protect the rights of minorities.

Children need the best kind of parents we know how to achieve—mature, giving mothers who can offer assurance and security to the child in his infancy; mature, responsible fathers who can teach their children effectively the demands and the rewards of adult responsibility.

We need more people who can clearly see the nature of their moral and cultural values, who can see that these are man-made and are variable among men and who realize that these values are the historical precipitate of the attitudes and the lives of past men, whose judgments were every bit as fallible as our own.

We need people who can question their own beliefs, because questioning beliefs is the only scientific way to treat them. This requires that we should be continuously thoughtful about our ways of bringing up children: that we should question our beliefs about schedules; that we should even question our pedagogical permissiveness.

We need people who are not afraid of the real world, who meet reality with confidence, for the answers lie in the real world and not in our defense mechanisms.

We need people who can meet new problems and new situations with spontaneity and with free, unbound energy, uncommitted to the emotional defense of a fixed position. There are enough of those who will measure everything new by the old shibboleths, who will call upon the old, protective, compulsive formulas to do their thinking for them.

We need more people who can see that reality is not the same as the method of looking at reality. There are many different languages in which to describe the world, but it is the same world, for all that it is apperceived with different grammars. And no one language, nor all of them put together, adds up to the real world.

The world is full of ideas. What we need is more individuals who can take ideas out of the area of emotional belief and hotly argued faith, and detachedly put these ideas to work to prove their validity or to expose their inadequacy.

What we ask for, fundamentally, is not for adherence to any cultural faith so far as content is concerned. Rather we ask for individual human maturity, and for everything that would facilitate that maturity. We ask for people who can humanly communicate with one another, for the wider the difference that is bridged the greater the triumph. Differences are our safety, for we surely do not know all the right social, economic, and political answers, and only out of differences can the human experiment succeed.

A young mother once read her little boy an animal story about a "kind-hearted owl." Weeks later he asked her, out of the blue, the at-first baffling question, "What *kind* of hearts do owls have, Mother?" Mother racked her brains for several days, to track down the source of the question in order to understand how to answer it. The child's "misunderstanding" was really a pointing out of the double meaning of the word "kind." I think this is a charming illustration of how children have the priceless quality of teaching us our arbitrarinesses, if we can learn. Children meet life anew; they give us a fresh appreciation of our own unclarity, they shock us with a realization that our shibboleths are not stubborn reality. For this reason, if for no other, children are our hope, and probably our salvation, ultimately.

Children need the best kind of parents we know how to achieve—mature, giving mothers, who can offer assurance and security to the child in his infancy; mature, responsible fathers who can teach their children effectively the demands and rewards of adult responsibility.

Reprints available in about 4 weeks

For the World's Children

(Continued from page 149)

behalf of children that is now being launched.

The United States, as might be expected, is the chief contributor: It matches contributions of other governments on the basis of $2.57 for every $1, and for this purpose $100,000,000 has been authorized, of which $75,000,000 has been appropriated through June 1949. So far, under that formula, the Fund has drawn $55,000,000, and is now seeking contributions from other governments, on the basis of which it can draw out the remainder.

While the United States contribution is the largest in total, other countries have contributed as generously on a per capita basis. The Australian contribution, to cite one example, amounts to approximately $1 a person. Canada, New Zealand, South Africa, Switzerland, and Uruguay are well to the fore, on the same basis, and interestingly, Czechoslovakia, France, and Poland, which are recipient countries, are among the large contributors. Measured against what a country has to give, many of the smaller countries' contributions take on great size.

Many nations contribute

The largest contributor, in proportion to its population, is Iceland, which, through the United Nations Appeal for Children, gave the equivalent of almost $4 a person. Australia, Canada, New Zealand, South Africa, and the United Kingdom each raised more than $1,000,000 through the appeal; the United States, approximately $600,000. Reports from Denmark indicate that large sums will be collected there through the appeal now in progress, the money to be used for the antituberculosis vaccination program. These figures are cited to show the widespread support the Fund has received not only from governments, but from individuals, but even so, there is not money enough to meet the needs.

Meanwhile there are calls upon the Fund as urgent as any that it has yet met. In Italy alone, nearly a million children receive the UNICEF supplementary meal, and as many more are in need of it. In Greece a quarter of a million children are in the refugee camps, and for many, the little meal UNICEF helps to provide is the only nourishing food they have from day to day. In the Palestine area 350,000 mothers and children are homeless; and, as in Greece, they look to the Children's Fund for help. In China, even greater numbers are in desperate need.

Elsewhere, in other countries of the Far East, in the Middle East, and in the Americas, the needs of children are no less grave for being long standing.

In Europe the food situation has eased somewhat. Three of the UNICEF-assisted countries — Finland, France, and Hungary—are requesting no further assistance in food supplies. The others, though, still need the Fund's help, for milk will be in short supply at least until the summer of 1950, and will not reach prewar levels until later in some countries.

Even when the food need is completely met there will still be other great needs left by the war, needs put into the background only because so little could be done about them. In the health field, only the preventive work has been undertaken, not the curative.

In the social-welfare field, the problems can only be imagined. In this country the child without a father is the exception; in some classrooms in Europe, a third of the children or more are in this category, their fathers killed or missing.

There is no reason to think that the special problems of these children, individually, are any less serious than those of the child in similar circumstances in the United States. So, one can multiply many times over the number of children in need of special care in our own communities—the dependent, the homeless, the delinquent—and still have no fair grasp of what has happened to the children of war-devastated countries.

The need is great and grave

The Charter of the United Nations states that that world body was brought into being to save succeeding generations from the scourge of war, but there is first this present generation. A start has been made, through the Children's Fund, in meeting at least a part of that responsibility.

Reprints available in about 4 weeks

To Combat Cerebral Palsy

(Continued from page 151)

official health agencies this situation will be improved in the near future.

Another obstacle is the fact that already available services often fail to come together into a team approach. In other words, we find so often in a community small segments of care being given by a variety of agencies, with very little joint planning and frequently without knowledge that someone else is doing similar or related jobs. I personally feel very strongly the need for cooperative planning and maximum use of existing facilities before superimposing a new plan or program.

Community should pay for cerebral-palsy program

The third obstacle is one that is chronic with all health-department service programs—that is, lack of money. This type of care is very complex and very expensive and to my mind must be assumed as a community responsibility if all children are to get the best care.

I have naturally been speaking largely of the health services needed by these children. But the educational program necessary is the backbone of an adequate rehabilitation service and in many areas the worst off financially and in personnel.

I mentioned a moment ago that these same obstacles were present in most programs of service for children. I would like to take this opportunity to express my personal conviction regarding the healthy development of services for children with cerebral palsy.

An integral plan

I am convinced that the most sound and permanent progress will be made if programs, both health and educational, will be integrated with the over-all community plan for services to handicapped children. This, of course, does not preclude special emphasis on the techniques and facilities particularly required for this diagnostic group. It does help avoid duplication of service and certainly leads to the most efficient use of public and private funds and to the most efficient use of highly skilled professional personnel, of whom we have so few.

Reprints available in about 4 weeks

• FOR YOUR BOOKSHELF

YOUR JOB: A guide to opportunity and security, by Fritz Kaufmann of the staff of the New York State Department of Labor. Harper & Bros., New York, 1948. 238 pp.

For everyone who wants to work in a job suited to his abilities and personality this small volume gives a large amount of very pertinent information. It is, as the preface states, "a book about jobs—about choosing a job, finding a job, holding a job, progressing on a job, and changing to a better job. More than that, it is a book which describes a worker's rights and responsibilities under current social and labor laws. It is a book for people who give advice as well as for those who seek it."

One section of the book is directed to the inexperienced young worker; this should be of particular value in helping to orient young people to the world of work and in assisting them to make a wise occupational choice.

The book should be useful not only to workers, but to vocational counselors.

Louise Q. Blodgett

REPORT OF THE THIRD NATIONAL CONFERENCE ON CITIZENSHIP, under the auspices of the National Education Association and the United States Department of Justice, Washington, D. C., May 16–19, 1948. Published by the National Education Association of the United States, 1201 Sixteenth Street NW., Washington 6, D. C. Single copies, 50 cents. Quantity discounts: 2 to 9 copies, 10 percent; 10 to 99 copies, 25 percent; 100 or more copies, 33⅓ percent.

"Three faiths have we: Legislation, education, and participation; and the greatest of these is participation. Participation means that all of us, everyone, regardless of faith, race, sex, ethnic background, regardless of nationality, get together. Participation means that the world gets together to solve its problems. This is an ideal to which we hold with strength and tenacity." These words, from the Report of the Third National Conference on Citizenship, express the spirit of this series of conferences.

The first of the conferences was held in Philadelphia in May 1946, as an outgrowth of the work of the Citizenship Committee of the National Education Association. The second conference was held in Boston, May 1947. Both these conferences had the advice and cooperation of the United States Department of Justice. For the third conference, held in Washington, May 1948, the Department of Justice became cosponsor with the National Education Association. The fourth of the series will be held in New York, May 15–18, 1949.

The objectives of the third conference were:

To reexamine the functions and duties of American citizenship in today's world; to assist in the development of more dynamic procedures for making citizenship more effective; and to indicate the ways and means by which various organizations may contribute concretely to the development of a more active, alert, enlightened, conscientious, and progressive citizenry in our country.

Centering on the theme, "Citizenship—rights and responsibilities," the program was divided into three parts: (1) The world-minded American citizen; (2) Basic human rights and attendant responsibilities; (3) Citizenship in action in the local community.

Nearly 400 organizations and agencies were represented at the conference.

• IN THE NEWS

Social Legislation Information Service Expands its Program

Anticipating that the Eighty-first Congress will consider an unprecedented volume of measures affecting the general welfare, the Social Legislation Information Service, Inc., is expanding its program and expects to provide service to 2,000 additional organizations.

The Social Legislation Information Service is a nonprofit, public-service organization, which publishes a weekly bulletin giving a complete but simplified analysis of Federal bills affecting families and communities in the broad areas of health, education, welfare, housing, employment, and recreation. These bulletins also announce congressional hearings and report important amendments and action taken so that its readers are aware of the status of bills in which they are especially interested.

The officers of the Social Legislation Information Service are: President, Mrs. Eugene Meyer, of the Washington Post; vice president, John Dewey, professor emeritus of philosophy, Columbia University; Mrs. Dorothy Canfield Fisher, author, and member of the Committee on Youth Problems, American Council on Education; Homer Folks; George J. Hecht, publisher, Parents' Magazine; Leonard W. Mayo, president, Child Welfare League of America; Most Reverend Bernard J. Sheil, director general, Catholic Youth Organization of the Archdiocese of Chicago; C.-E. A. Winslow, professor emeritus of public health, Yale School of Medicine; Secretary, Mrs. Gertrude Folks Zimand, general secretary, National Child Labor Committee; treasurer, George Gallup, director, American Institute of Public Opinion.

Inquires about the service are invited by Mr. Bernard Locker, Executive Director, 930 F Street NW., Washington 4, D. C.

• CALENDAR

Apr. 30–May 7—National Boys and Girls Week. Twenty-ninth annual observance. Further information from the National Boys and Girls Week Committee, 35 East Wacker Drive, Chicago 1, Ill.

May 1–8—National Family Week. Seventh annual observance. Sponsored by the Interfaith Committee, representing Jews, Catholics, and Protestants. Information from Rev. Richard E. Lentz, International Council of Religious Education, 203 North Wabash Avenue, Chicago 1, Ill.

May 2–5—National Tuberculosis Association. Annual meeting. Detroit, Mich.

May 2–6—National League of Nursing Education. Annual convention. Cleveland, Ohio.

May 15–18—Fourth National Conference on Citizenship. New York, N. Y. Auspices of the National Education Association and the United States Department of Justice.

May 16–18—National Congress of Parents and Teachers. St. Louis, Mo.

Regional conferences, Child Welfare League of America

May 1–4—Midwest Regional Conference. Chicago, Ill.

June 6–7—New England Regional Conference. Portsmouth, N. H.

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What Is Your State Doing About Child Labor?

State child-labor standards stood up well under the strain of war-born manpower shortages, as Lucy Manning points out in this issue of *The Child*. At the end of 10 years that included the defense period and a time of postwar adjustment, as well as actual wartime, the standards were fully up to their prewar level, and even a little higher.

This reflects great credit on the State and national organizations that have worked so long to improve child-labor laws. For it was the firm foundation that these groups laid in the past, as well as their intensified efforts during the decade of extra strain, that enabled the standards to weather the storm. In some States help came from children's code commissions or wartime children's commissions; these helped to center attention on the needs of child workers.

But we must not be complacent; the job of protecting child workers is not yet done. It is true that child labor today is different, more scattered, less concentrated, and less dramatically stirring. This is because child labor in factories and sweat shops has been done away with through State and Federal laws. And so much progress has been made in checking child labor in some employments that the public conscience has been soothed into believing that child labor is practically abolished.

Instead, child labor is increasing. Twice as many boys and girls 14 through 17 years of age were working in 1948 as in 1940. Some of these are in occupations in which child labor is regulated by well-enforced laws. But large numbers of boys and girls are in jobs with long hours and bad working and living conditions, and many of these children and young people get little protection from child-labor laws.

If the public realized all this, more people would protest to their legislatures. As Edith Stern points out in the February 1949 issue of the *Woman's Home Companion*, most people are against child labor when they recognize it. They would unite to oppose employment of children in factories.

But they do not recognize the evils of child labor in, for example, the work of 14-year-old agricultural laborers. If they see a child picking beans for a commercial grower, they may say that the work does not seem unsuitable. They say this because they do not know that the child left school in the third grade. And that he is working 10 hours a day. And that he is living in a shack on the edge of an irrigation ditch.

Again, when people are served by a 15- or 16-year-old waitress, it does not occur to them that she may be carrying heavily laden trays far too many hours a day.

Because many of us do not recognize evils like these, says Mrs. Stern, the public conscience is not aroused about child labor today as it was in the past, when the people successfully demanded that their State legislatures enact the early minimum-age laws.

Still, were it not for the support the public gave to bills upholding child-labor standards in the 10 years just over, the legislatures could not have brought about the favorable balance that we had at the end of the decade 1939–48.

The wartime emergency is over, but success in protecting child workers through legal standards still depends on public support. As I write these words many State legislatures are in session, and a number of bills have been introduced concerning child labor. Most of these bills would raise standards; a few would lower them.

It is too early to measure success, but we are hopeful that these 1949 sessions will continue the trend that brought a net gain in the period 1939–48.

Our experience in that decade has strengthened us in the conviction that we must conserve our youth power by allowing children to grow up unhampered by premature or injurious employment and prepared for citizenship by a good basic education.

Such conservation requires more than legal standards, essential as they are. Our young people need to be trained and guided, and when they are ready for employment they need to be directed into the right kinds of jobs.

And progress in fulfilling these needs, not only through better laws, but through better schools and better youth programs generally, comes only when the necessity for these things is recognized at the grass roots.

Behind all the progress that has been made in the past lie State and community planning. And future progress will come only as we have a citizenry aware of the needs of childhood and youth and united for action.

Beatrice McConnell

Chief of Legislative Standards and State Services, Bureau of Labor Standards, U. S. Department of Labor

VOL. 13, No. 10 APRIL 1949

the CHILD

published monthly by the
Division of Reports
CHILDREN'S BUREAU
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SOCIAL SECURITY ADMINISTRATION
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CHILDREN'S BUREAU
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Publication of THE CHILD, monthly bulletin, was authorized by the Bureau of the Budget, May 12, 1936, to meet the needs of agencies working with or for children. The Children's Bureau does not necessarily assume responsibility for statements or opinions of contributors not connected with the Bureau. THE CHILD is sent free, on request, to public officials and libraries; address requests to the Children's Bureau, Federal Security Agency, Washington 25, D. C. For others, the subscription price is $1 a year; send remittance to the Superintendent of Documents, Government Printing Office, Washington 25, D. C.

U. S. GOVERNMENT PRINTING OFFICE: 1949

MAY • 1949

the CHILD

TEAMWORK IN TEXAS

Lone-Star Counties Line Up for White House Conference

KATHERINE GLOVER

Information Consultant, Preparatory Activities, Midcentury White House Conference on Children and Youth, Children's Bureau

WHEN you fly over Lynn County, Tex., the farms and ranches stretch out below like great flat pancakes—200, 500, 1,000 acres in size. They form beautifully patterned panoramas with contours that look as if swirled by a giant scythe. Some of the land is planted to cotton, some to grain; on some, cattle range. Part of it is poor, "shinnery" land, as they say in Texas.

A dozen years ago, flying over Lynn County, you would have seen a different picture. There would have been no contoured planting to save the soil, nor terraces to hold the rain. This was Dust Bowl country. In 1934 some of Lynn County soil blew as far away as New York City. When you see neighboring farms planted after a common pattern it means that farmers and ranchers have teamed up in a cooperative effort for soil conservation.

Another kind of teaming up, less discernible to the eye, is taking place in Lynn County today. Citizens of the county are sitting down together for the first time to consider the conservation of children and map out cooperative action to meet their needs.

When the Texas Committee on Children and Youth in the summer of 1948 started planning toward the 1950 White House Conference on Children and Youth it considered the size of Texas—as large as New York, the New England States, New Jersey, Pennsylvania, Ohio, and Illinois—and proposed that each of the 254 counties set up a committee to take inventory within its own borders of its children and the services to them.

A chairman was selected in each county, and the chairman asked to form a committee. A carefully worked out questionnaire was sent to each county in order to provide a uniform basis for the inventory.

The person agreed upon as the logical chairman in Lynn County was Mrs. Fred McGinty, of Tahoka. As the mother of three children, with a busy home life, and a cotton grower in her own right, Mrs. McGinty felt she already had as much responsibility as she could handle. Her fellow citizens, however, knew that when she undertook things she got them done. The final argument came from her husband when he quoted Scripture: "To him that knoweth to do good, and doeth it not, to him it is sin."

Mrs. McGinty took over with the will and thoroughness with which she farms her spreading acres of cotton and manages her household. The questionnaire became a matter of great interest to people of the county. The several sections were assigned to different members of the committee.

Social organization lacking

In times past in this county, where the population is widely scattered, cases of child care were considered on an individual basis. With no county health nurse or doctor, no welfare worker, no truant or probation officer, any emergency usually landed on the doorstep of the county judge. He called in what help he could get. Needy cases were paid for out of court fines. The $36 a month for the meager library, open two afternoons a week and housed in the courthouse in Tahoka, came from the same source. Social organization for children, or for any other purpose, was practically nonexistent.

When the committee sat down with the questionnaire, listing more than 700 questions in nine different fields—child care and protection, education, health,

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Many States are actively planning for children and youth in preparation for the Midcentury White House Conference. Each State has its own individual differences in organization and plan of action. These differences give evidence of the democratic basis of the planning and the strength of local initiative. The vitality of the White House Conference is rooted in this local citizen action.

This story of how Texas is going about its big job is presented as one example of the Nation-wide picture. Reports on other State programs will be given from time to time in THE CHILD.

youth employment, housing, recreation, religion, library service, handicapped children—facts and figures showed up a realistic picture of children in their county and the environment in which they are growing up. Eighteen percent were living in substandard housing; that meant the flimsy shacks which shelter the Mexican migrant workers upon whom farmers depend to pick their cotton every year, and the shanties in which some of the Negro and low-income white children live.

The questionnaire shows no foster-care provision in the county, no day-care facilities for the mothers who must work in the fields, no public health or welfare services, 200 children not enrolled in school because of farm work; for recreation only one area in the county (for white only); two picnic centers; one gymnasium, in the Tahoka school (available to Negroes once a year for basketball and tournaments); one softball diamond; no community recreation center; no tennis courts or swimming pools in the county; no golf course. Schools are closed after school hours and during vacation. No bookmobile serves the county. The books in the library had been provided by a local club.

The farmers in Lynn County waste practically nothing of the products of their farms. Uses have been found for peanut hulls and an infinite number of uses for cottonseed. There are vaccines and serums to prevent and treat practically everything that may cause loss or damage to their cattle.

What the questionnaire revealed was that the saving of children through preventive care has not been so carefully planned for in Lynn County. Nor has it in other Texas counties—in fact, in many other parts of this country of ours.

Mrs. McGinty told her fellow workers, when she distributed the questionnaire: "After you've filled it out, make out a list of other questions of your own and pin them on the back, and check on the answers from time to time."

Just smoking out the facts isn't enough. The questionnaire becomes a tool for social action. Facts are translated into terms of children—the gay, lively brood pouring out of the consolidated school when the bell rings; the children of migrant families who attend no school in the fall of the year, but join their parents in the fields; the children of the tenant-farm families. The questionnaire has become an important document in Lynn County. In the McGinty home a copy lies on the table in the living room, in close proximity to the Bible.

Actions speak in Lynn County

At the very top of the list of recommendations when she sent in the questionnaire the chairman wrote: "More action and less talk." That's the slogan they have taken in Lynn County.

The major needs as listed were: Recreation; enforcement of the compulsory school-attendance law; provision for health and welfare needs of children; more church recreation programs and facilities; more provision for parent education; State aid for the library.

A nerve center has been touched in this West Texas county, which links it up with the other counties in the State and with the cooperative action for children throughout the Nation. "We are a little county of little people," says Mrs. McGinty; "We go about things not as they do in Washington, but as Texans, according to the ways of our own county, but we want to be a part of what's happening in Washington for children."

After a county such as Lynn blocks out its needs, the State committee, to which the questionnaire is returned, helps to find the resources available to meet them. Needs in the different categories are channeled to the sources within the State which can lend help: Those relating to library services are referred to the State librarian, welfare services to the Department of Public Welfare, and so on. Where there is no State resource, as in the field of recreation, that gap shows up and makes evident a State need. Sometimes colleges or universities within or adjacent to the county can offer aid on some of the problems.

A neighboring county to Lynn is Lubbock, with the growing, thriving city of Lubbock as the county seat and the shopping and industrial center for a wide area of the western-plains section.

Lubbock County is just launching its plan of cooperative action for children and youth. It has many more resources to draw upon than has Lynn County. For one thing, Texas Technological College, one of the top-ranking in its field, is located there, with all its facilities and resources of faculty, research, and cultural opportunities.

Lubbock County might well lend a hand to a less well-endowed neighbor like Lynn. For instance, a county library is about to be opened in Lubbock. The city is providing the building and services, and bonds have been issued to pay for the books. A bookmobile attached to the Lubbock Library could serve the people of Lynn and possibly other nearby counties. This kind of neighborly cooperation among counties is one of the hopeful outcomes contemplated as a result of the State-wide action for children and youth.

Landscapes like this in Texas mean that farmers have learned to cooperate so as to save the soil. Now citizens in Texas counties are teaming up for the conservation of children.

The eyes and hopes of Texas are on youngsters like this happy, husky, farm boy. County by county, the people of Texas are at work to give each and every child his rightful chance.

A widely representative committee, including members of public agencies as well as lay citizens, is getting into action in Lubbock County, beginning with the filling out of the questionnaire. The chairman, Mrs. H. F. Godeke, has long been active in PTA work. Around the table with her sit representatives of the various public agencies: Health; welfare; education; employment; the court; the probation office; and others, including a representative of the Salvation Army, the Council of Churches; and other leading citizens.

Last winter, when Texas bore the full brunt of the severe cold and snow, Lubbock citizens faced an emergency. Numbers of the Mexican migrant workers who had stayed late after the harvesting season were caught in their midst, without adequate food, shelter, and clothing. The city and county welfare funds were depleted by the emergency. The citizens of Lubbock rallied to the call of the mayor and by pooling their resources they took care of the situation.

In many parts of Texas social planning and organized action are still new. Matters are handled on an individualistic basis. The spirit of independent action of the defenders of the Alamo and the Texas rangers is still strong. Against this background, what is happening in relation to children in Texas today has added significance.

Counties have common aims

The White House Conference Planning Committee of the Texas Committee for Children and Youth has taken the Children's Charter as its platform. A copy accompanies each of the questionnaires sent out to the counties. Its 19 points, setting forth the rights of children, serve as the yardstick by which counties measure their services to children and youth. These common aims and the common task of inventorying the needs of children are a bond that ties the counties together.

The metropolitan counties, such as Dallas, have a different task from that of the more rural counties. The Dallas County Committee for Children and Youth looks upon the questionnaire as an educational instrument to arouse public opinion, to rally support for expanding already existing facilities and for new services to which the survey points a need. A series of public meetings is planned for the discussion of the facts presented and the recommendations of the committee.

The size of the fact-finding task made it advisable for the Dallas committee to divide into 22 different subcommittees. Health, for instance, was subdivided into four sections: General, mothers and newborn infants, infants and preschool children, and children of school age. Chairman of the Dallas committee is Howard G. Large, vice chairman of the Family and Children's Division of the Dallas Council of Social Agencies. Under his direction, work on filling out the questionnaires started the first of December 1948, and the returns were in by early February 1949. Many persons cooperated with the committees in the county in gathering the facts. Members of PTA's, Dads' Clubs, and other civic groups lent a hand in the different communities. Panel discussions on the subjects covered by the questionnaire attracted public attention. In Dallas such groups as the Citizens Committee on Juvenile Welfare of the Council of Social Agencies lent assistance, clerical and other. Students of sociology at Southern Methodist University helped to analyze the data.

With the facts all in, a general meeting of the committee members was planned, at which the five major needs were selected in order of importance; and intensive work was initiated to meet them. A core group of seven to nine persons will draw up a report outlining the major needs which the survey defines, with suggestions for how they may be met, and listing resources available to help with the job. By fall this working document—a report on children to the citizens of Dallas and Dallas County—will be ready for presentation.

It will serve as an impetus to citizen action. A program will be set forth. It will include goals that hopefully may be accomplished by the date of the White House Conference in 1950; others will involve long-range planning.

Not all the plans will start from scratch. Many will include on-going activities which need speeding up or intensified action. The White House Conference serves as a spur toward increased accomplishment.

Of the 254 counties in Texas, about 200 have already set up committees for children and youth in the State-wide planning for the White House Conference. Others are in process of organizing. While all the counties are bound together by a common purpose and many of their needs are the same, there are differences because of the wide differences between rural and urban counties and the great variety of cultural and social patterns.

The eastern cotton country still reflects the transplanted traditions of the old plantation life of the South. The southern-border sections are strongly affected by the large populations of Latin-Americans and their traditional culture. Oil and kindred industries influence the life of other sections. In the western-plains and Panhandle regions, still known as cow country, wind and space and frontier ways prevail, even while the latest methods of farming, industry, and luxury living crowd in.

Top-ranking objectives in planning for children differ, partly because of these sectional differences. Of the first 45 counties sending in returns on the questionnaire, health and recreation topped the list of the major needs, 38 counties ranking each of these two needs first. Education came next, with 32 counties; and libraries followed, with 30 counties reporting needs in this field; and next, religion, with 28 counties specifying this.

In East Texas counties, such as Robertson and Fort Bend, rich agricultural areas, with many large plantations growing cotton and grain and cattle, the old and the new are in close juxtaposition. On the beautiful plantation of the chairman of the Fort Bend County Committee for Children and Youth, Mrs. Joseph A. Wessendorff, is the grave of Mrs. Jane Long, known as the mother of Texas, because of her heroic stand against the Indians when left with her young children and a handful of deserting soldiers to defend a fort.

The broad stretches of land planted to cotton that surround her grave are cultivated with the latest farm implements, and 30 miles away is the impressive city of Houston with its modern skyscrapers, on its outskirts the fabulous new Shamrock Hotel, built with the riches of oil. Yet in Fort Bend County, with the prod of the questionnaire of the Texas Committee on Children and Youth, coordinated planning for children has begun for the first time.

Nearby farms are cultivated by tenant-farm labor, 75 percent Negroes. Each year 25,000 to 50,000 migratory workers come in to harvest the crops. A considerable population of Latin-Americans live in the county. These situations present a complex of problems as the Fort Bend County committee sits down to plan for children. Children of the land-owning families, of the industrialists and industrial workers of the several small industries in the county, of the farm workers—children of different racial groups and widely different economic backgrounds—make up the total.

The important thing in this East Texas county is that for the first time the people know the facts, and are beginning to deal realistically and earnestly with them.

The committee started out with a membership made up of representatives of the official agencies, but is enlarging its numbers to include a wider representation of public-spirited citizens. With the facts as an instrument, the committee will try to rouse public opinion to secure such needed services as a county welfare unit and a county health unit. A fine new county library has already been completed, and a bookmobile serves the county. A program of recreation to reach all children is one of the major considerations of the committee. These are immediate and important aims upon which they are set. What is of greater importance is the new consciousness of the rights of children which is stirring and the cooperative will to do something to secure those rights.

For the whole child

The words of the chairman of the committee stayed with me as I came away from a meeting of the Fort Bend committee in the county courthouse in Richmond: "We want to keep our focus upon the whole development of the child—every child—not to think of children in bits and pieces, education for their minds, or health for their bodies, or children in special need. We want all the things that help all children to grow to their full, potential development."

And they mean to work to this end in Fort Bend, consecrated to the purpose of developing their own citizen strength through teamwork.

The Robertson County committee, under the chairmanship of Mrs. Judd Collier, is embarking upon a program to lift the standards of services to children all down the line as a result of the facts revealed by the questionnaire.

They have set as their goal a 12-months' program of education; year-round use of the schools; 12 months' recreation, with paid leadership; increased public recreation facilities; adequate library service; a thoroughgoing health program, with a health unit, which the county once had, but lost; and mental-health guidance.

These are their goals. To reach them they see the need of a State program in these fields, with legislative support. "We know our needs," says the county committee chairman, "but we must have some help from the State."

Some of the voluntary citizen agencies are being spurred to action by the results of the questionnaire. The great need for recreation, for instance, which shows up in many of the counties, has roused the interest of the Texas Junior Chamber of Commerce. At its annual meeting in Galveston in March of this year it endorsed a proposal to promote—and help to provide—urgently needed recreational facilities as disclosed by the Texas Committee on Children and Youth. That will be its special project in relation to White House Conference planning for children and youth in Texas.

Representatives of local junior chambers of commerce, through county committee chairmen, will get information on the recreation needs revealed by the questionnaire. When they have been investigated and approved they will promote public interest through their own programs and contact with other civic groups, stimulating campaigns through the press and radio and in other ways.

The counties mentioned here are a mere sampling of the many counties at work. The situation is as varied as the Texas topography and resources.

When all the facts from all the cooperating counties are in, they will be

(Continued on p. 173)

THE RIGHT START

Early Foundations For Job Satisfaction

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THE PHILOSOPHY underlying the establishment of the Federal Children's Bureau 37 years ago, that the child is a unit and all his varying needs and interests are indivisible, has stood the test of time. Although our concept of child welfare has broadened vastly over the years, and the services of the Federal Government in this field are far beyond anything contemplated in 1912, the close relationship of all phases of child welfare has been increasingly demonstrated; and new activities have, for the most part, been incorporated in the Children's Bureau.

The chief break in this pattern—and to the writer an unfortunate one—was the separation of the child-labor and youth-employment program from the rest of the Children's Bureau when the latter was transferred to the Federal Security Agency in 1946. The child-labor program, one of the earliest concerns of the Children's Bureau, remained in the Department of Labor because of its close relation to labor programs and employment regulation. The fact that child-labor and youth-employment activities are now organically separated from the Children's Bureau, however, does not alter the fact that the development of Federal child-labor work over a period of 30 years brought ever-increasing evidence that the needs of children and youth in relation to employment are part of their general needs as young people.

This is so, not merely because child labor is detrimental to health and education, and because the health needs of working children and their need for normal family life, economic security, community services, and education, are the same as those of other children. There is an even more basic respect in which activities relating to child labor and youth employment are an integral part of child welfare—for every child will eventually work in some capacity.

Work is not merely an economic necessity; it is part and parcel of the fabric of living. A person's adjustment to, and satisfaction in, his occupational activities, whether in industry, a profession, or the home, is an important factor in his general effectiveness as a person. A child-labor and youth-employment program, therefore, must be concerned with all the implications of "work" in relation to the growth and development of young people.

In the past, attention has rightly been focused on the dangers of employment of children at too early an age or under conditions that jeopardize their education, health, and development. Great strides have been made in preventing such harmful employment, and markedly so during the past 10 years when Federal regulation of child labor has been in effect under the Fair Labor Standards Act. There are still child-labor sore spots and inadequate State laws. Especially is this true for children employed in agriculture—the many thousands, as young as 8 or 10 years, who help their families to eke out a living as sharecroppers and migrants—probably the most deprived of America's children in terms of home life and of educational, health, and recreational services.

But as the years go on, the enforcement of restrictive child-labor laws should become less of a problem. Amendments to the Federal law now

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under consideration by Congress will, if enacted, extend its provisions to most major industries, and State laws to reach the remaining areas of child employment are gradually coming into line. The belief that the child under 16 belongs in school, and that conditions of employment for minors under 18 years should be regulated, has become pretty deeply embodied in American thought. Other factors are also tending to reduce child employment, such as the mechanization of industry and of agriculture, eliminating many of the hand processes which have always utilized cheap child labor; the increasing demand on the part of employers for high-school graduates; the growth of unions and the beginning of unionization in agriculture: minimum-wage laws; and the gradual recognition that large-scale commercial farms are industrial enterprises, which must be brought under labor regulation.

The progress in reducing child labor has been accomplished by an increased awareness of other aspects of youth employment. Just as our expanding knowledge of children's needs and of child and adolescent psychology has opened up new vistas of thought and action in relation to child health and education, so, in the field of youth employment, problems are being considered and activities developed (though on a relatively small scale and primarily in large cities) which, some 25 years ago, were completely ignored in programs for child welfare. The change in the term "child labor" to "child labor and youth employment" is but one evidence of this expanded concept.

Each year about a million boys and girls start full-time work. For many of them this is an abrupt change. One day they are pupils in school, an institution operated solely for their welfare. The next day they are on their own, a cog in the vast machine of industrial enterprise, their place in it determined hit-or-miss, part of a system operated primarily for profit, with the needs of the individual quite incidental.

A transition as short as this is a poor start for future occupational satisfaction. A person's vocational adjustment is determined, not only by the adequacy of his wages and the conditions under which he works, but, to a considerable degree, by the preparation he has received for working life, the guidance he has been given in selecting his work, and his early job experience. The first job is a milestone in the child's life—it looms up as a step toward adulthood and independence. A wrong start—getting fired soon after he starts, or finding himself in a job that is beyond his abilities or for which he is not prepared, or in one that neither utilizes his capacities nor offers him opportunity to develop them, or that presents problems which he cannot understand—problems of industrial relations, or personal relations—is a frustrating experience for a young worker and may adversely affect his future working life.

The degree to which young people are prepared for and aided in their early vocational adjustment may affect their attitude to work for years to come; it may mean the difference between a person who welcomes employment as a normal and desirable part of living and one who goes through life regarding work as a necessary evil having nothing to do with his other interests and activities.

A program related to youth employment is, therefore, a matter of public welfare and of governmental concern. The vocational needs of the individual as he grows up, progresses in school, enters industry, and has his first work experience, must be recognized as on a par in importance with his needs in the fields of health, education, and welfare. For the extent to which they are met will be one important factor in determining his effectiveness as a parent, a citizen, and a person.

These high school boys are getting practice in the field of work in which they hope to get their first real employment. This should make the transition from school to work easier.

Work as a continuing experience

What can be done to insure satisfactory vocational adjustment for young people? The lines of approach are closely interwoven with efforts in the fields of health, education, recreation, labor, and welfare. Preparation for work should begin at an early age, long before the child is ready to think of any kind of job. It starts in preschool days, when the wisely educated parent trains the child to put away his toys and gradually to assume responsibility for certain household tasks. It continues in school, where the child, from kindergarten on, has certain definite responsibilities. All through school life, work experience continues, changing in nature and content, developing from individual tasks to group work that may be of value to the school, perhaps including volunteer community

projects as the child grows older, and including, for some, part-time work during the high-school years.

But there is much more to the preparation of youth for vocational life than work experience in home or school or industry.

The role of guidance in vocational adjustment

Much of this preparatory work centers in the schools. But it is the concern not only of educators, but also of those working in other fields of child development—a fact which has been recognized by the Office of Education's Commission on Life Adjustment Education for Youth, which is seeking to develop, on National, State, and local levels, close cooperation between school people and other interested groups.

Foremost in importance is the development of guidance services for children from the early years on, using guidance in its broadest sense and including educational, vocational, and personal counseling. Robert C. Taber, director of the division of pupil personnel and counseling of the public schools of Philadelphia, has said:

"Educators are just beginning to appreciate the extent to which a satisfactory personal adjustment in the early grades is basic to an eventual sound, vocational adjustment."

Similarly, the report of the Subcommittee on School Counseling, of the National Conference on Family Life, recommended in 1948 that "the services of a competent school counselor should become the basic right of every child and youth . . . counseling should be available throughout the entire school career—from kindergarten through post-high-school education."

Guidance services are not confined to the schools. Some private organizations have services of specialized types and for specialized groups of children and young people, but the school is the one place which can reach every child prior to the time he enters industry. But only one-sixth of the junior and senior high schools in the country now have the services of either part-time or full-time counselors and guidance officers. And guidance in the elementary schools has hardly made a start.

Guidance services should include interest, aptitude, and achievement tests; advice to a child *on an individual basis* about his school work and school adjustment; consultation on family problems; help in selection of school courses and school activities; advice, as he approaches school-leaving age, on whether he should leave school, or undertake part-time work, or continue to give full time to his education; vocational information and counseling. The role of a school guidance department, however, should not be limited to aiding the child—and his parents—with his problems and decisions. The information and experience which guidance services build up, if properly evaluated, should make the guidance service a key agency in pointing up weaknesses in the school and changes needed in its curriculum and activities.

A child needs counseling and guidance to prepare him for vocational life, not only when he is about to look for a job, but also throughout his school years, and even in his preschool days. And such service should be available to him through his early years of employment.

The curriculum and vocational preparation

"Beginning with the elementary school, and particularly in the early years of secondary education, the foundations of economic understanding and preliminary vocational orientation should be laid. This function is integrally related to general education. It should be clearly recognized in the curriculum and work of the school. All children should know the meaning of work, should come to have respect for all types of honest labor, should learn in school—and if possible, to some extent out of school—what it feels like to do real work, and should at adolescence begin tentatively to identify themselves with some general idea of future occupational life."

This statement, adopted in 1940 by the Educational Policies Commission of the National Education Association, and the American Association of School Administrators, suggests the role of the schools in preparing children for working life. Translating this concept into reality in the school curriculum is a task in which representatives of labor, industry, and agencies working with youth can assist the educators.

Early in his school life, the child should begin to get acquainted with the world of "work." Before he leaves school he should be well-grounded in a knowledge of industrial development—the history, methods, and aims of organized labor; labor legislation; collective bargaining; and so forth. When this training should start, how it should be introduced into the curriculum, what educational media should be used, is a problem to which little attention has been given except sporadically here and there. One school in Newark, N. J., for instance, is conducting this spring a 1-week educational experiment, in

which officials of the American Federation of Labor will serve as "visiting professors" to conduct talks and discussions for high-school seniors on questions relating to labor.

It is impossible, within the scope of one article, to develop all the points at which the curriculum, directly or indirectly, can contribute to the future job satisfaction of young people, or even to suggest the range of current thinking in this field. However, mention should be made—even in a very incomplete listing—of the increasing emphasis being placed on prevocational work and the need for providing a student with opportunity for experimentation in vocational choice; consideration of the value of nonvocational school-work programs and of cooperative vocational part-time programs; the relationship between specialized vocational education and general education; the need for providing the student with a variety of skills, rather than narrow specialization, to fit him for the complex and changing industrial life of today; and education for homemaking and family life—the one occupation in which all school children will eventually participate.

Just as it is impossible to separate "life" into categories, so it is impossible to compartmentalize work of the school into separate functions. The aim is to educate for the whole of living, and that aspect of life which is called "work" is related to all the rest.

"All youth," says the Commission on Life Adjustment Education, "need instruction in human relations, civic obligations, consumer education, work experience, physical and emotional health, and international affairs. Such studies help smooth the continuing perplexities adults face in trying to be effective workers, consumers, citizens, and parents. Such studies face up to the demands made of all individuals who would live whole and significant lives."

Home influences

Another important factor in the child's preparation for successful working life, and one which to some degree affects the success of whatever the school may try to do, is his home environment. The family's economic status and security, the attitude of the parents toward education, their understanding of the aims and activities of the school, their opinions—or prejudices—about the social prestige attached to different occupations, their ability to understand the personal problems of their children, their attitude toward their children's limitations—as well as their talents and ambitions—all play a part in the child's future vocational adjustment.

Some of these are primarily a matter of parent education and guidance. Others involve basic social and economic legislation, such as minimum wage, social security, health insurance. For any measure that tends to increase and stabilize family income affects the child's working life—both in terms of adjustment and, in many cases, more concretely in terms of the amount of schooling he receives. We have not by any means reached the day when no child is forced to leave high school because of poverty—either because his family cannot meet the expenses incidental to school attendance or because his earnings are needed at home. Even less have we reached the day when it has become financially possible for every boy and girl who can benefit from a college education to secure one. The development of student financial aid through loans and scholarships is, except for veterans, practically an untouched field. Probably all thoughtful persons would agree that every child should have an opportunity to continue his education to the limit of his capacities. But this is lip service only, and we are still very far from realization of the goal.

Health factors

Not to be overlooked in a program of vocational adjustment is the need for expanding health services for young people. The result of inadequate school health work is evident in the number of boys and girls who reach "working paper" age and seek employment certificates, only to be refused an opportunity to work because of physical defects which should have been corrected years before. It is taken for granted that a young person, before he makes the transition from school to working life, should be in good physical condition. But that desirable state of health should already have been reached as a result of a health program conducted during the school years and should not await the final moment when he plans to leave school that he may enter employment.

In England, health examination is not required before the child goes to work, but there is a system of periodic health examinations for young employed workers. We have nothing comparable to this in the United States. Nor have we built up any body of knowledge about the effects on the health of young people of different types of employment, hours of work, and so forth.

Services for youth who have left school

A youth-employment program should not stop at the time a boy or girl secures a job. Special counseling and placement services for young workers should be available all through the early years of employment. Many a young person finds that his first job is not what he thought it would be and not what he wanted; he encounters difficulties he does not know how to meet; he develops ambitions along other lines. He wants to consider a change in employment and needs advice as to available job opportunities, what they require, and what they offer in terms of immediate work and future advancement; what facilities for further training there are in the community; what industries have apprenticeship programs; what ones offer other types of on-the-job training; what educational opportunities (not merely vocational) are open to youth. A body of research on job satisfaction is becoming available, and points strongly to the need for such services for young people. In a *Fortune* survey (quoted in "Job Satisfaction Researches of 1946–47," *Occupations*, December 1948), a sampling of workers were asked: "If you could go back to the age of 15 and start life over again, would you choose a different trade or occupation?" Fifty-seven percent replied "Yes."

Last, but by no means least, there must be constant attention to the conditions under which young people are employed and the maintenance of good labor standards. Wages, hours, and employment in hazardous work are generally recognized as a matter for governmental regulation, and there must be increasing vigilance to see that such laws are enforced and that low-standard laws are strengthened. We need to

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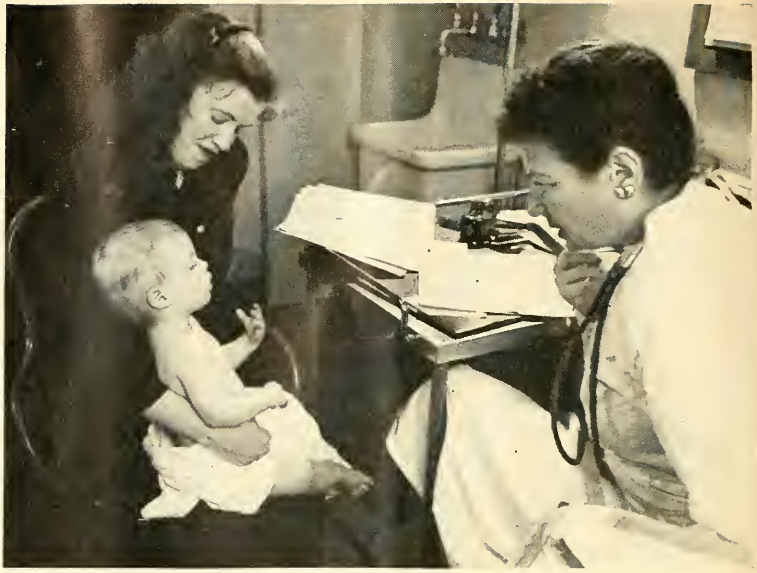

THERE IS ALWAYS MORE TO LEARN ABOUT CHILDREN

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THE PAST half century has seen the birth and rapid development of pediatrics as a special field in medical practice and teaching. A long step forward was taken as early as 1860, when a professor of diseases of children (Abraham Jacobi) was appointed at the New York Medical School, but development of the science of pediatrics was not prosecuted vigorously until the late nineties.

Children's bodies studied

In the first 30 years of the twentieth century an intense and rapid development in this branch of medicine took place. With startling and sweeping discoveries in the fields of bacteriology, pathology, physics, biochemistry, and pharmacology, and their bearing on pediatrics, teachers and students alike were deeply engrossed in a highly successful effort to place this branch of medicine on a critical, scientific, objective basis.

Babies and older children were weighed, measured, and X-rayed; their body secretions and excretions analyzed; and their food intake and output accurately measured.

Planning the formula for the baby's food, once a prerogative of the mother or grandmother, became so complicated that the pediatrician was almost forced to use a slide rule in estimating the proper proportions of proteins, fats, and carbohydrates; and for years the poor mothers struggled hours to make the milk mixture exactly according to specifications and were warned not to change it without the advice of the pediatrician.

We might term this period in pediatrics the *era of scientific somatic pediatrics*, the emphasis all being on the child as a biological unit.

During this period ideas concerning the psychological care of the child were derived largely from the theoretical and experimental studies of psychologists who knew little or nothing of children in their normal environment.

The outstanding book of the period for mothers, on the care and feeding of children, was written by the eminent clinical pediatrician, L. Emmett Holt, in 1894; and this famous baby book remained the mother's bible until long after its last edition in 1929. [*1*]

Given at a symposium on psychosomatic pediatrics of the American Academy of Pediatrics.

Dr. Holt's point of view is expressed in the following quotations: "Babies under 6 months old should never be played with; and the less of it at any time the better for the infant." When played with, "they are made nervous and irritable, sleep badly, and suffer from indigestion and cease to gain in weight." They may be played with, he said, "if at all, in the morning, or after the midday nap; but never just before bedtime."

Sucking, nail-biting, dirt-eating, bedwetting, and masturbation were listed under the topic, "Bad habits." In handling these problems, Dr. Holt suggested various physical restrictions: "Children with such tendencies should be closely watched and every means used to *break up* these habits early."

Little regard for parent-child relationships

In 1917 John B. Watson formulated his well-known theory of behavior in terms of reflexes or inherited responses. Although this theory was based on experiments in conditioning and unconditioning children to the fear of animals, it influenced pediatrics tremendously because it provided pediatricians and parents alike with seemingly new suggestions for the rearing of children. Still, after a decade or so of faith in behaviorism, "parents themselves were beginning to question, and even resist, advice about child care which was rigid, artificial, mechanical, unfeeling, and fitted more to animal experimentation in the conditioning experiment than to a home and parent-child relationship," as Milton J. E. Senn [2] recently wrote.

Psychological aspects neglected

The pediatrician of this era of scientific somatic pediatrics, like his teachers, was so deeply engrossed in the somatic aspects of disease that he had little time or interest for the psychological aspects of his specialty, and relatively no knowledge of them. Mothers were not allowed to use their own judgment in feeding their babies. Babies usually were fed every 4 hours by the clock. Mothers were urged not to spoil them by rocking or fondling, not to take them up when they cried, and to leave them alone in their rooms except for a brief playtime in the afternoon. In other words, it was the prevailing belief that early infancy was the time to begin inculcating strict regularity of habits in order to avoid spoiling the child and to prevent undue dependence on the parent.

Beginning, however, in the late twenties, voices were heard protesting against the psychology of the era of scientific somatic pediatrics. Sigmund Freud and his followers were beginning to learn what happened in later life to infants and children reared under this rigid regime. Adolf Meyer of Johns Hopkins had been teaching that man is not a biological unit only, but a psychobiological unit, and, as such, the entire individual, not merely his somatic life, must be appraised.

In 1928, Clara M. Davis [3] conducted the first successful experiment of allowing infants of weaning age to exercise choice in the amount and type of food they wished to eat. This study represents one of the first radical departures from the old, stereotyped rules of infant feeding; a complete break from the teaching that the physician alone can estimate exactly what the child needs, without regard for the child's wishes as to quantity, quality, or interval between feedings.

And two decades later, Aldrich [4] has reported on the successful feeding of 668 infants for a year on a "self-regulating regimen, designed to allow the babies free choice as to intervals of feeding and amounts of food, although the kinds of foods included in the menu were prescribed."

In 1935, Grover F. Powers [5] of Yale termed this new dawning era in pediatrics the *psychologic era*. He emphasized the fact that "the pediatrician must think not less in terms of principles of nutrition but definitely and decidedly also in terms of the personality of the child and of those in his immediate environment, especially, of course, of the mother." "In the past," said Dr. Powers, "emotional difficulties were not recognized as of major importance since they seemed to be present only in isolated cases, but now these problems are widespread, constituting a major portion of the practice of many pediatricians. The reasons for this increase are many; the problems are sequelae, in part—possibly in large measure—of a strict, dogmatic attitude in the application of the advances in the science of nutrition to the practice of infant feeding. No plea is being made for irregularity for irregularity's sake, but a protest is being made against inflexible standardization for its own sake. It would be wise for the physician to worship the baby more, and the measuring stick, the scales, the graduate, and the clock less."

The child psychology of the so-called scientific era of pediatrics was derived from hearsay, folklore, tradition, and theoretical and experimental psychology. The child psychology of the new, or psychological, era of pediatrics, now rests on a firm foundation of carefully controlled observations from the field of anthropology, from studies of primitive peoples, from very careful studies in abnormal psychology, from the contributions of the school of psychoanalysts who have unearthed and disclosed the causes of adult neuroses as dating back, usually, if not always, to psychological injuries in early infancy and childhood. And lastly, this new psychology rests on many carefully controlled observations on large groups of infants and children and on the interesting contrasts in homes where at least one child has been reared under the old system and one or more under the new.

From the study of primates it has been shown that the chimpanzees are the only primate group which have a happy family life. The young are exclusively breast-fed for 3 to 6 months, and sometimes for 2 to 3 years. The mother starts playing with her baby at an early age—beginning about the third month and continuing until the infant is matured.

"Chimpanzee mothers get to understand their babies thoroughly. They are able to forestall their needs and to interpret correctly every infantile posture and movement. These animals are sufficiently intelligent to manage their group affairs peaceably and with a fair degree of independence and some measure of happiness for each individual member." [6]

Few Okinawans psychotic

These observations suggest that only where the young are reared in emotionally happy surroundings can we expect peace-loving, cooperative adults.

In studying the Okinawans after our terrific bombardment and capture of the island from the Japanese, James Clark Moloney, [7] a psychiatrist, was struck

by the rarity of psychotic persons on Okinawa Shima. At a U. S. Naval Hospital on Okinawa, among 1,500 native patients, the neuropsychiatric division housed only 30. Among 500 shell-riddled civilians at Koza, only two were psychotic.

Dr. Moloney says: "I do not believe that these people are constitutionally sounder than Americans. Nor do I believe that their mental health can be entirely ascribed to the destruction of weaklings through disease, permitting only the strong to survive and propagate. Rather, in my opinion, this psychological stamina stems from the excellent start the Okinawan child gets in life. He is well-mothered."

The Okinawan child is breast-fed almost from the moment he is born, whenever he wishes to suckle, and as long as he wishes, until he is 2 years of age or even older. During that period, the mother seldom deserts her child. By means of a "wraparound" she carries him on her back wherever she goes, about her housework or out in the fields where he slumbers, being rocked to and fro by the mother's movements.

"No attempt at bowel training is made until the child is over 2 years of age. Then he is directed to follow the bowel habits of his older siblings. In this training, there are no threats made, no force used. They are not necessary. The child, by this time, has achieved a psychological health commensurate with his age. He takes to the bowel training naturally enough. . . .

"One not familiar with psychological maturative processes would be inclined to believe that the Okinawan brand of mothering would produce a self-centered, a spoiled, an undisciplined child. On the contrary, they show themselves capable of harmonious social cooperation."

Good mothering brings good dispositions

Similar studies among Indian tribes in the Southwest and Mexico have revealed similar findings. That is, where you find a tribe of kindly, generous, cooperative, peace-loving natives, study will reveal that their babies, like the Okinawan babies, have been well-mothered.

In their splendid book, Babies are Human Beings, Dr. and Mrs. C. A. Aldrich [8] point out: "This frequent insistence that children should be denied gratification is undoubtedly due to the prevalence of 'spoiled children.' In my experience most spoiled children are those who, as babies, have been *denied* essential gratifications in a mistaken attempt to fit them into a rigid regime. Warmth, cuddling, freedom of action, and pleasant associations with food and sleep have been pushed out of the way to make room for a technique. The lack of these things is so keenly felt that by the time babyhood is past, such children have learned their own efficient technique of whining and tantrums as a means of getting their desires."

Pediatricians who have been in practice a long time have, by this time, seen numbers of families in which at least one of the children was reared under the old rigid regime and one or more under the newer method. With few exceptions, the former children are the ones who are spoiled, not the latter. They usually are uncertain, apprehensive, demanding, selfish, jealous, emotionally unstable, and fundamentally passive, in marked contrast to the opposite traits in those children who were emotionally satisfied in the first 2 years of life.

As a result, then, of all these various observations, the pediatrician of today, who has accepted this evidence and thrown off the shackles of the father image in his teachers, leads the mothers along quite a different path from that of even 10 years ago.

If the baby is bottle-fed, his mother should hold him while she is feeding him; and she should try to make every mealtime as warm and personal an experience for him as possible.

How do doctors advise mothers now?

1. We now urge the mother to breast-feed her baby, provided she is physically able and emotionally free to do so. If she bottle-feeds her baby, we urge her to hold him and make each feeding period as warm and personal an experience as possible.

2. We now regard the baby as the best judge, not of *what* he may eat, but when and how much.

3. At various age levels we add to the baby's diet food which *may* be taken, not *must* be taken.

4. We tell the mother that it is not important *when* she begins bowel training, but *how*. The child should be *led* to cleanliness, not driven. The same is true for bladder training.

5. We now tell her that thumb-sucking, head-rolling, hair-twisting, crib-rocking, and masturbation are all comfort-seeking mechanisms utilized by practically all babies at some time. These in themselves are all entirely harmless and can safely be ignored. They are sensual pleasures. They usually indicate that a baby or child is not deriving sufficient emotional satisfaction from his environment.

6. We now know that love, fondling, play, rocking to sleep, feeding when hungry do not produce a spoiled child; that bowel and bladder training and other discipline may be safely deferred; that the new approach is essential if the infant is to make a happy, friendly, successful adjustment to life; that such approach enables him to accept later the absolutely necessary restrictions on his freedom without hate, fear, resentment or frustration, because such restrictions and discipline come from those who have completely satisfied his fundamental cravings for love, security, and satisfaction.

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Teamwork in Texas

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compiled. The result will be a picture of the State such as never has been presented before, a picture in terms of children. It will be so clear and irrefutable that he who runs may read—legislators and public servants, as well as Mr. and Mrs. Average Citizen.

The Texas Committee on Children and Youth, which set the ball rolling for this county-by-county program of fact-finding and action in preparation for the Midcentury White House Conference, is a voluntary group, made up of representatives of 70 State-wide organizations and agencies and citizens interested in the welfare of children and youth. The organization of county committees in preparation for the White House Conference is under the direction of a subcommittee known as the 1950 White House Conference Planning Committee of the Texas Committee for Children and Youth. Mrs. George Abbott is chairman. Mrs. Abbott, who works wholly as a volunteer, should be listed among the famous "Texas brags." In her tireless spirit and devotion to this Texas campaign for children she is a not-unworthy successor to the defenders of the Alamo.

She is aided by an able committee, which includes in its members representative young people who speak for youth. And several of the Federal and State agencies and voluntary groups lend valuable assistance in this cooperative task.

While the committees were established in the counties primarily to carry through the questionnaire, most of them are planning to carry on into the future. The questionnaire serves merely as a springboard. The significance of the activities of these Texas counties is not how far they have progressed, but the process by which they are progressing. Through their citizen committees they are embarking upon a fresh pioneering, welding together their energies in behalf of children, drilling for a new kind of oil, the oil of human resources. If they keep at the task, it may yield in years to come far greater wealth than the oil and gas of all their wells.

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know a great deal more about what young people may and may not safely do; the point at which regulation is desirable and the point at which it begins to reduce chances for young people to get started in worth-while work.

From this general summary, which no more than high-lights some of the activities and services that comprise a constructive program in the field of youth employment, two facts stand out:

1. That it is a vast program which must serve the needs of many millions of young people of widely different interests, abilities, and aptitudes; and yet, to be effective, must reach the individual.

2. That the planning and execution of such a program requires close cooperation between agencies, public and private, Federal, State and local, working in the fields of labor, social security, health, parent education, general education, guidance, and placement.

It should be obvious that no blueprint for a comprehensive program of youth employment can be developed or put into operation all at once or on a Nation-wide scale. Many communities are already carrying on activities along some of the lines mentioned. Probably for many years general progress will be somewhat sporadic, as individual communities, forging ahead and pioneering, extend their efforts along these lines. But it is essential that all of these local efforts be carefully studied to measure their effectiveness and their applicability to other communities, that there be organized large-scale basic research and exploration in this field.

The problem will assume increasing importance in the decades ahead, as a result of the increased birth rate of the war years. The United States Bureau of the Census points out that from 1951 to 1958 there should be "a gradual increase (totaling nearly 300,000, or 14 percent) in the number of youngsters seeking employment for the first time, and between 1958 and 1964 a sharp increase (totaling over 800,000, or nearly 37 percent)."

America cannot afford to let young people of working age be absorbed haphazardly, and without preparation, into our complex industrial life.

IN THE NEWS

For Long-Term Care of Ill Children

Health and welfare departments—State and local—in 10 States were represented at a bi-regional conference on long-term care of ill children, held March 16–18, 1949, by the Arizona State Departments of Health and Welfare in cooperation with the Children's Bureau of the Federal Security Agency.

The States included in the two Federal Security Agency regions participating in the bi-regional conference are:

Region 9: Montana, Idaho, Wyoming, Utah, Colorado.

Region 10: Washington, Oregon, California, Nevada, Arizona.

Federal agencies represented, besides the Children's Bureau, were the Public Health Service and the Office of Vocational Rehabilitation, both of the Federal Security Agency.

The co-chairman of the conference were Edith P. Sappington, M. D., Children's Bureau Medical Director, Region 10, San Francisco, Calif.; and Donald J. Bourg, M. D., Children's Bureau Medical Director, Region 9, Denver, Colo.

For Social Work in India

The Indian Conference of Social Work was established in November 1947 at the first All India Conference of Social Work, held in Bombay, which was attended by 480 delegates from all over India.

The main objects of the conference are: To study social problems; to guide the progress of social work on scientific lines; to coordinate social services; to serve as information exchange for social work and to promote professional training of social work. The central executive committee includes 57 members from all over India.

A permanent secretariat is being established at the headquarters in Bombay to carry out the objects of the organization. A preliminary survey of social-service institutions, on an all India basis, is already in progress, and it is hoped that the directory when complete will provide the necessary basis for coordination of social services. In course of time a quarterly journal of social work will also be published by the conference, besides authoritative studies on Indian social problems. Provincial branches have been opened in Madras, West Bengal, Central Provinces, and Delhi and it was expected to form nine other branches before the second annual session, which was scheduled to meet in Madras, December 18–22, 1948.

The Indian Conference of Social Work is affiliated with the International Conference of Social Work.

The executive secretary of the conference is Mr. B. Chatterji, Indian Conference of Social Work, Tata Institute of Social Sciences, Nagpada Neighborhood House, Byculla, Bombay 8, India.

Summer Courses

Louisiana State University. School of Social Welfare. Baton Rouge 3. Short courses: Services for children in foster care; supervision in social case work; trends in social welfare; (July 5–22). Workshop in welfare administration (July 25–August 12) Juvenile delinquency; Social services for children (June 10–August 12).

Columbia University. New York School of Social Work. New York 10. Four series of summer institutes in social work. Some of the courses: Understanding and working with the adolescent in a social group work setting; normal development of children; goals in legislation for children and youth; social case work as a service to children; social case work practice in adoption; social work with displaced persons. Series I, June 20–July 1; Series II, July 11–July 22; Series III, July 25–August 5; Series IV, August 8–19.

Smith College. School for Social Work. Northampton, Mass. Seminars organized around three general aspects: Social case work, psychiatry, and supervision. New topics this year: Teaching of case work, and case work writing and interpretation. Graduate seminars for experienced social workers in private and public agencies (July 11–21).

Vassar College. Twenty-fourth Vassar Summer Institute. Poughkeepsie, N. Y. Seminars for parents in child development, family relationships, and other subjects; workshops for teachers in nursery-school, day-nursery, and child-care programs; special education for the hard-of-hearing child; special programs for professional workers in parent education, child guidance, group therapy, radio and public speaking. The institute includes a 24-hour school for children from 2 to 10 years of age. July 7 to August 4.

Our Lady of the Lake College. Graduate School of Social Service. San Antonio, Tex. Special summer session for teachers, visiting teachers, school nurses, attendance officers, counselors, and guidance personnel. Part 1, Seminar on school social work (June 6–11). Part 2, social case work; dynamics of human behavior; and organization of social work (June 20–July 30).

University of Denver. School of Social Work. Denver 10, Colo. Graduate professional education in five specializations: Family case work; child welfare; social group work; psychiatric social work; and administration (June 20–July 22 and July 25–August 26).

FOR YOUR BOOKSHELF

CHILDREN'S BOOKS FOR SEVENTY-FIVE CENTS OR LESS, by Marion L. Grimes. April 1948. 41 pp. 35 cents. BIBLIOGRAPHY OF BOOKS FOR CHILDREN. 1947. 117 pp. 75 cents. Both published by the Association for Childhood Education, 1201 Sixteenth Street NW., Washington 6, D. C.

With the price of books going up, the Association for Childhood Education is calling attention to the many excellent books for children that still sell for very little. Both of these carefully compiled pamphlets, "Children's Books for Seventy-five Cents or Less," and "Bibliography of Books for Children" carry lively descriptive annotations, and the bibliography suggests as well the ages at which children will most enjoy the various books.

Marion L. Faegre

BREAST FEEDING; a guide to the natural feeding of infants, by F. Charlotte Naish, B. A., M. B., B. Ch (Cantab.) Oxford University Press, New York. 1948. 151 pp. $3.50.

Into this small book is packed a wealth of common sense and of practical knowledge about a highly controversial subject. Breast feeding, like rooming-in, has strong advocates from the naturalists and from the psychiatric groups. On the other hand, the observant physician sees many infants in his own practice and his confreres' grow into healthy, happy individuals on artificial feeding and is in consequence confused. Dr. Naish, though believing in the value of breast feeding, is not an extremist. The following passage illustrates her approach to the problem:

"There are some writers who apparently consider breast feeding a universal panacea. I do not share this view. I even think it dangerous, for it sometimes leads to underfeeding a child for the sake of keeping it on breast milk alone. There are unquestionably cases in which breast feeding is impossible;

others in which it is inadvisable; a good many in which it is inadequate by itself. Therefore the first problem is to decide when it should be used. The second problem is, when breast feeding has been decided on, to make it successful."

Especially useful are the chapters dealing with preparation of the breasts antenatally and with techniques of feeding during the first week.

The time of introduction of solid foods, as suggested by Dr. Naish, is very much later than it is in this country; also the time for dropping out the evening feeding. The diet is less varied than it is in the usual American practice, and more heavily weighted with carbohydrate foods.

The book is full of practical suggestions which should be helpful to all physicians, but especially to the young doctor who has not had time to learn these details through experience.

Katherine Bain, M. D.

CALENDAR

June 6–10—American Medical Association. Annual session. Atlantic City, N. J.

June 9–11—National Probation and Parole Association. National conference in cooperation with Ohio Probation and Parole Association. Cleveland, Ohio.

June 12–17—National Conference of Social Work. Seventy-sixth annual meeting. Cleveland, Ohio.

Some other organizations meeting in association with the National Conference of Social Work:

American Association of Group Workers.

American Association of Medical Social Workers.

American Association of Psychiatric Social Workers (June 10–12).

American Association of Social Workers.

Child Welfare League of America.

Committee on Services to Unmarried Parents.

Florence Crittenton Homes.

National Association of School Social Workers.

National Association of Training Schools.

National Committee on Homemaker Service.

National Council on Social Work Education.

National Probation and Parole Association (June 9–11).

National Publicity Council for Health and Welfare Services.

CHILD HEALTH DAY, 1949

BY THE PRESIDENT OF THE UNITED STATES OF AMERICA

A Proclamation

WHEREAS the Congress, by joint resolution of May 18, 1928 (45 Stat. 617), has authorized and requested the President to issue annually a proclamation setting apart May 1 as Child Health Day; and

WHEREAS every citizen should do his utmost toward safeguarding and improving the health of the Nation's children:

NOW, THEREFORE, I, HARRY S. TRUMAN, President of the United States of America, do hereby designate May 1, 1949, as Child Health Day; and I invite all agencies, organizations, and citizens interested in the physical and mental well-being of children to consider on that day how best to promote in their own communities during the coming year definite programs of action designed to help our children to grow into healthy and responsible individuals dedicated to the principles of democracy.

IN WITNESS WHEREOF, I have hereunto set my hand and caused the Seal of the United States of America to be affixed.

DONE at the City of Washington this sixteenth day of April in the year of our Lord nineteen hundred and forty-nine, and of the Independence of the United States of America the one hundred and seventy-third.

Harry Truman

By the President:

Dean Acheson

Secretary of State.

June 19–23—American Association of University Women. National convention. Seattle, Wash.

June 19–23—American Physical Therapy Association. Annual conference. Boston, Mass.

June 28–July 1—American Home Economics Association. Annual meeting. San Francisco, Calif.

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Page 170, Esther Bubley for Children's Bureau.

Page 172, Children's Bureau.

Dr. Eliot Goes to WHO

When Dr. Martha M. Eliot, our Associate Chief, leaves the Children's Bureau in June to become Assistant Director General of the World Health Organization she will be taking a logical step in a career of ever-widening activity and leadership.

Dr. Eliot came from a line of pioneers in intellectual and spiritual affairs. From childhood her character was shaped toward devotion to the search for truth, compassionate understanding of her fellow men, and development of her great resources of mind and spirit.

After graduating from Radcliffe College she was for a time a medical social worker, and this experience led her to study medicine.

Three years after receiving her medical degree at Johns Hopkins she joined the pediatrics staff of Yale University School of Medicine, where she did clinical and research work as well as teaching. Soon Grace Abbott, then Chief of the Children's Bureau, persuaded her to enter the Children's Bureau, assuring her that she could continue her work at New Haven through arrangements between the Bureau and the university. For 10 years she engaged in notable studies of the growth and development of children, especially demonstrations of community programs for prevention and control of rickets. Her interests, however, began to branch out from clinical practice and research, in which field she had won an international reputation, into application of medical knowledge through community organization and national programs.

In 1934 Dr. Eliot came to Washington to become Assistant Chief of the Children's Bureau. Her first job was to develop the basis for the maternal and child-health and crippled children's provisions of the Social Security Act. After the act was passed, in 1935, it was Dr. Eliot's resourcefulness and know-how that translated the legislation into a working program. She was quick to see the importance of advisory committees consisting of both lay and professional members. She studied at first hand the problems of the States. And she showed great administrative ability. At the same time she was giving leadership to the Bureau's research activities in the field of maternal and child health. She gave personal attention to the Bureau's bulletins for parents.

When British civilians were bombed Dr. Eliot studied methods of protecting children in case similar danger came to the United States. She went to England in 1941 as a member of a War Department mission to study civil defense there and later was lent to the Office of Civilian Defense, to advise it on plans of evacuation of children and other aspects of civil defense. Her outstanding wartime work, however, was organization and direction of the Emergency Maternity and Infant Care Program, under which more than 1,500,000 servicemen's wives and infants received maternity and infancy care through State health departments, paid for by Federal funds supplied through the Children's Bureau.

Since the war Dr. Eliot has worked to improve State and community health services for mothers and children and to lay the foundation for expanded research in child life.

Dr. Eliot's international activities on behalf of children began with a study of maternal and child-health activities in Europe in 1935. She has since worked with the League of Nations and with UNRRA, and was vice chairman of the U. S. delegation to the International Health Conference in 1946. She was one of the three United States delegates to the first World Health Assembly, in 1948, and is chairman of WHO's maternal and child-health committee.

In the World Health Organization Dr. Eliot will be responsible for operations in the broad field of public health.

Dr. Eliot has given a quarter of a century to working toward the goal of a fair deal and an even chance for every child in the United States. Now her concern will be the children of the world.

The Children's Bureau will continue to bear the stamp of her leadership, resourcefulness, comradeship, and devotion. The contribution that she has made to its work through the years can never be replaced.

Katharine F. Lenroot
Chief, Children's Bureau.

VOL. 13, No. 11 MAY 1949

the CHILD

published monthly by the
Division of Reports
CHILDREN'S BUREAU
Managing Editor Sarah L. Doran
Art Editor Philip Bonn

FEDERAL SECURITY AGENCY
Oscar R. Ewing, Administrator

SOCIAL SECURITY ADMINISTRATION
Arthur J. Altmeyer, Commissioner

CHILDREN'S BUREAU
Katharine F. Lenroot, Chief

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Publication of THE CHILD, monthly bulletin, was authorized by the Bureau of the Budget, May 12, 1936, to meet the needs of agencies working with or for children. The Children's Bureau does not necessarily assume responsibility for statements or opinions of contributors not connected with the Bureau. THE CHILD is sent free, on request, to public officials and libraries; address requests to the Children's Bureau, Federal Security Agency, Washington 25, D. C. For others, the subscription price is $1 a year; send remittance to the Superintendent of Documents, Government Printing Office, Washington 25, D. C.

U. S. GOVERNMENT PRINTING OFFICE: 1949

JUNE • 1949

the CHILD

HOME HELPS IN GREAT BRITAIN

THERESA MACDONALD

Home Help Specialist, Women's Voluntary Services, London, England

HOME HELP SERVICES in Great Britain have begun to flourish under a Government that is committed to a complete program of welfare services. But the original legislation was promulgated by a conservative Government, added to by a wartime coalition, and carried into effect largely with the assistance of a voluntary organization that received every assistance from each Government in turn. The result is that no home-help service in the world is so strongly backed by Government and local authorities. Yet we have developed a service that is anything but bureaucratic. It has the enthusiasm, ideals, and freedom characteristic of the professions that largely originated in voluntary social service.

Our beginnings were modest. Apart from isolated experiments by small voluntary societies like the Jewish Sick Room Help Society, which started one in 1895, nothing much happened until 1936, when public-health legislation, consolidating a 1918 act, gave certain local authorities, called welfare authorities, power to pay women to do domestic work for expectant and nursing mothers. (The local authorities in Britain, by the way, are county and county-borough councils and borough or urban or rural-district councils; these consist of a local elected and unpaid council. Such councils control paid permanent officials, like small editions of Parliament with its civil service.)

Each local authority concerned was to find the money required, although it was not compelled to do anything about starting a service.

The net result of this was negligible. Nearly all local attempts failed through lack of organization and failure to recruit workers. It was really nobody's business and everybody was too busy doing something else. Then the war came along and we had certain pressing matters to attend to for a few years.

Wartime, however, increased the demand for home helps. Women were needed in industry. People were becoming more tired. Hospital accommodation was overtaxed. Blitzing and a building standstill ensured that we were not going to have adequate hospital space for years to come. Home helps were more urgently needed than ever, and the Government recognized that the basis had to be broadened to cover all kinds of health cases.

A rather clumsy title, "Home and Domestic Help Schemes," was evolved in connection with fresh legislation in 1944, which indicated that help would be available under the scheme to assist in maternity cases and in cases of illness generally.

All this was very encouraging, but there just weren't any home helps to

This is the fourth of a series on home-making service that *The Child* is publishing. The first of the series, printed in August 1947, discussed the principles of this type of service. Others described the work in Finland (July 1948) and Australia (November 1948). Additional articles are planned.

subsidize, except in one or two places where small local schemes got going. It is one thing to give local authorities statutory powers: it is another to get a plan to work.

Just before the 1944 legislation was enacted, the city of Oxford Women's Voluntary Services asked the city's permission to carry out an experimental home-help scheme for, and with, the city council.

The W. V. S., which originated as a women's organization for civil defense, enrolled over a million women during the war, extending its activities to any job that needed to be done, from running canteens to acting as the distributing agency for the wonderfully generous American gifts of food and clothing.

Now in peacetime it continues its activities as a social-service organization, for it exists to help the state nationally and the local authorities locally, and it has a complete national coverage. That is, when it is at its peak mobilization, it has a representative in every street and village in the country. It is completely nonpolitical, like the British civil service, but because it is voluntary it can do a good many things in the way of experiment and improvisation that officials cannot do.

The Oxford City Council gave its blessing, and the great experiment in home helps began. There were several things to clarify. The first was the purpose of the scheme; the second, how it would function; the third, the status and conditions of the workers; and the fourth, recruitment and publicity. Right away it was decided to call the workers "home helps" and the scheme simply "the Home Help Service."

A place in the health services

The purpose was clearly to form an adjunct to the health service of the community. This ruled out all forms of what has come to be termed "private" service; that is, the ordinary domestic help which anybody might require. Owing to the shortage of domestic workers generally, there is a Government-sponsored scheme to deal with this latter problem. The National Institute of Houseworkers has been formed to improve the status of such workers and to recruit and train women who will attend, daily or hourly, any household or will even become permanent domestics to private individuals. The National Institute of Houseworkers, by the way, has managed, after much uphill work, to open nine training centers by 1949 and hopes to turn out about 700 workers this year. In 1944, however, all this was still at the paper stage.

Home helps, then, were to concentrate on *health*, with maternity cases in families with children under 5 as top priority. A medical certificate (from a doctor, a district nurse, or a hospital almoner) had to be presented by every applicant for help. It was to be an emergency service; that is, it would take only short-time cases. This excluded old people and those with chronic illnesses. It is realized, however, that when enough home helps were available, something would have to be done to help these people in their difficulties. Finally, the service was intended for any health emergency, without discrimination between the rich and the poor. Those who could pay would be expected to pay; those who could not would get the service anyway, contributing according to their means.

New career for women

As it was to be a "public" health service, it was determined that the helps, when recruited, would be the paid employees of the local authority and responsible to it, not to the householder. The householder would pay the city council and not the help. It was envisaged that a home help would visit an average of two or three houses a day, and that her work would be planned so that she was not faced with a week's washing at each house and was not kept too long in unpleasant surroundings.

In recruiting, this emphasis on a public-health service was a trump card. The home helps quickly realized that they were employees of the city, like nurses, school teachers, or policemen, and that they were visiting houses as workers in the health service and not as drudges to be bossed about. We were able to appeal to an admirable type of woman. Although very little training was possible to begin with, we soon found women who could do practically everything in the home when the mother was confined to bed. They could do housework, shopping, cooking, taking the babies out: in fact, they could take complete charge of the home. Both married and unmarried women were accepted, a small proportion on a part-time basis. The quality of the home helps resulted in an almost entire absence of complaints; on the contrary, letters of appreciation very soon became a feature.

While the administration lay in the hands of a voluntary organizer, the conditions of employment for home helps were fixed to compare favorably with those of shop and factory workers. The city guaranteed a fixed weekly wage for a 42-hour week, with overtime for Sundays and legal holidays, and with compensatory leave in certain cases. Holidays with pay were included. The support of the Ministry of Labor (employment) was obtained and employment as a home help was given a priority equal to that of factory work. This permitted women to enter this occupation with priority. (At that time all labor was controlled.)

A brochure was produced and distributed through employment exchanges, entitled "A New Career for Women." That was what we were determined to make it.

As a seal on this, the Dowager Marchioness of Reading, chairman of Women's Voluntary Services, who is well-known in the United States, offered to equip the first 40 home helps with a snappy indoor and outdoor uniform. Later schemes have adopted this excellent idea, although clothing restrictions have proved some hindrance to its universal adoption.

An office with a telephone was provided by the city. All was now set for the scheme.

The scheme was launched with a big public meeting, attended by the principal city officials, representatives of the Ministry of Health, and other distinguished visitors and speakers. At the close, *one* woman volunteered to enroll as a home help! Our first recruit! Anyhow, a start had been made and people began to talk. It was not long before we enrolled 10, 20, 30 women. In our first year about 90 women applied. Of these, 40 became

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permanent workers, and a few "permanent part-time." The present strength is about twice that number.

Experience recorded in Oxford dossier

From the day when the scheme was envisaged until 2 years later, every stage reached and difficulty overcome was logged in a "dossier." This Oxford dossier was later to become the bible of hundreds of similar schemes. Problems included cost to patient; allocation of administrative costs; saturation point of recruitment; and the welfare, training, and so forth, of the home helps.

In the first year's working of the service in Oxford, home helps were provided for over 1,000 families (the population of Oxford is about 80,000). All classes used the service: University dons (professors, and so on), workers from the great Nuffield motor works; people in the few slums that still exist. The social implications of the scheme became plain.

For one thing, hospital accommodation in England is overcrowded, but a great amount of "out-patient" treatment is frustrated because the patient cannot rest and get someone to run her house. No official estimates have been made, but it is a good guess that the cost of home helps to local authorities and to the Ministry of Health, through assessment, has been partly saved in hospitalization costs.

Again, it was found that by adding home help to the other home-care services—that is, district nurses, health visitors, midwives—a great strain was taken off married couples. With this strain removed, couples were less likely to separate if illness struck the home, or if quarrels arose when an ailing housewife was unable to do her household duties properly.

The preventive side of home help had been apparent from the first. It is, of course, far better to keep people from becoming ill than to patch them up afterwards. So, whenever possible, we stepped in before things got too bad.

We also found that in poorer homes the home help was often able to advise the housewife on how to improve her management. Incidentally, if a house was too dirty, two home helps were sent to attack the job thoroughly at the start.

This "home help" will stay until the mother is again able to attend to her household duties.

Home helps save the day

The following are some of the kinds of situations in which a home help was used.

1. A mother, with two children aged 5 and 2, who was threatened with miscarriage each month during pregnancy, received help for 4 months. The doctor, as well as both parents, testified that she would probably not have carried her baby successfully without the service.

2. A doctor wrote that his patient could leave the hospital on a certain date "only if you can supply her with a home help."

3. A husband telephoned to say his wife was returning from the hospital with twins. The family would be satisfied with 3 hours of help daily.

4. A mother with three other children, having a baby at home, needed meals prepared for the children and two adults.

5. An old lady of 90, living alone, had broken her leg. Help was needed especially in early mornings to light the fire, prepare breakfast, and so on.

6. A professional woman, living alone, having had a minor operation, wanted a few hours' daily help for about a fortnight.

7. Mother with first baby, soon returning from the hospital. Husband wanted the flat cleaned up before her return, and then 2 hours' help daily.

8. Health visitor reported that a mother of six children was losing interest in looking after her home as a result of ill health and overstrain. Could help be sent until the woman becomes stronger and regains her normal outlook?

9. Hospital almoner on the telephone: If we can supply home help to a patient convalescing from appendicitis operation, she can be sent home immediately.

For training of home helps

At that time very little training of home helps was possible, but we arranged demonstrations, lectures, and talks. We were later able to negotiate with the National Institute of Houseworkers, which now accepts working home helps for examination for the diploma.

Out of the first batch of diplomas awarded by the institute, 21 went to home helps.

The majority of home helps will ultimately qualify for this diploma, which is of high standard and carries certain wage guarantees. This will ensure that the whole service is trained to a high standard.

Organizer is keystone

In 1946 the Ministry of Health examined such home-help schemes as then existed throughout the country and recommended the Oxford scheme, along with that of a London borough, as a model for all local authorities. The Ministry also incorporated our finding

that the success of a scheme depended on appointing a full-time paid organizer, who should be a good administrator, an enthusiastic recruiter, and a sympathetic person. The organizer, besides running a scheme day-to-day, would have to estimate the amount of help to be allotted to each family, and also to interview the "patient"; and she may have to perform the delicate task of assessing those who ask for reduced terms. This assessing is carried out according to rules laid down by each local authority.

At the same time, London headquarters of Women's Voluntary Services set up a home-help department to aid in the expansion of the service on a national scale. For the next 2 years, using the network of W. V. S., meetings were held up and down the country to pass on to local authorities the knowledge gained from the Oxford experience and to give publicity to the scheme.

Rural areas especially need home helps

It is interesting to note that home helps were first established successfully in towns. At one time it was thought there was not the same need in rural areas. Experience is beginning to prove, however, that the need may be even greater in scattered rural districts. Whereas at this stage one home help per thousand population may be adequate for a town, the ratio of home helps to the population may need to be higher in country districts.

In a survey of the development of the home-help service in five neighboring counties, two interesting facts emerge:

1. Decentralization of the service to the smallest possible unit of the community, particularly to the village, is essential to the smooth and adequate running of the scheme.

2. Despite the fact that decentralization is or will be general in each of the five counties, the *pattern* of administration varies.

Generally speaking, most counties develop their scheme piecemeal—first in one town and then in another—and gradually include the surrounding districts. By this means a few counties were able to report complete coverage by July 1948.

Recently, a bold experiment in Somerset proved successful. The county council decided to set up a complete service simultaneously throughout the whole country, using Women's Voluntary Services with its decentralized framework for purposes of organization. Within 6 months a country-wide service was established and in operation, with 273 home helps working. This was achieved with the help of Women's Institutes, and of members of W. V. S. in the villages, and in collaboration with district nurses.

The difference in cost between a county scheme in which all administrative overheads are borne by the county council and where one voluntary aid is used to the full, can be enormous. Each county council decides, however, whether or not it will use voluntary help.

Valuable indeed is the "home help" who can get along with the children of the household.

How organizers were trained

The next problem to be tackled, as had been foreseen, was the training of organizers. Local authorities were offering good remuneration to home-help organizers, but of course no specialized training yet existed. Already candidates were being sent to gain experience in model schemes, but something further was required. In conjunction with the Ministry of Health, Women's Voluntary Services began residential training courses for women who wanted to specialize as home-help organizers or who were taking up duties with local authorities. The background of knowledge and understanding had to be assumed—in whatever field this might previously have been—and specialized training on the organization and administration of a home-help service concentrated into 1 week, with follow-ups at model centers, refresher courses, and correspondence.

These schools, which are both exhausting and exhilarating, are held four times a year and are addressed by

(Continued on page 190)

MENTAL WINDOWS FOR HOSPITALIZED CHILDREN

SALLY LUCAS JEAN

Consultant in Health Education, National Foundation for Infantile Paralysis, Inc., New York City

AT BELLEVUE HOSPITAL, New York City, in a classroom for orthopedically handicapped children, a large low table holds a number of objects to illustrate story-lessons. Children just learning to read and write paste cardboard houses, model clay animals, make a pool to hold water, spray "snow" on paper trees to bring "winter." This waist-high table, with its world in miniature, expands the minds of small patients to conceive of the world outside. Many of them have known little beyond the hospital walls. It is significant that their favorite bunny in a frieze painted around the walls for Easter is pictured on crutches.

All hospitalized children, whether they are 2 years old or in their teens, need wide mental windows through which to view the world. The restraints and deprivations imposed on a child undergoing treatment must be offset by educational opportunities in the hospital which provide experiences for growth and development. Often the handicapped child is socially immature because he has come from a too-protected environment; or because he has never had the normal life of a child; or because he has been a misfit among other children. A well-rounded program of instruction, guidance, and recreation will develop his self-respect and capacity for adjusting when the time comes to go home.

No matter how severe his handicap, every child profits when he is introduced to group teaching. For example, less than 2 years ago, a 17-year-old—let's call him Jack—who is now happily attending regular high school in a wheel chair, was carried, a helpless cripple, into Bergen Pines (N. J.) Hospital for treatment. He was one of the "old" polio cases uncovered by the Bergen County Tuberculosis Association.

Disabled in his back, legs, and arms, Jack had been home-bound from the age of 4. He had had lessons from a home teacher, but no other outside companionship. When he entered the hospital, he seemed a hopeless bit of human wreckage, obesity adding to the impression he gave of low mentality. Nevertheless, it was decided to place him in the high-school class in the hospital, where he could stay all day.

At first, Jack was silent, withdrawn, expressionless. Then with understanding encouragement from the teacher and other members of the hospital staff, he began to emerge from his shell, and to respond, awkwardly at first, to praise and attention. Especially, with the companionship of other young patients, he developed a whole new language of expression. It was discovered that he was a good student with a will to learn and that his hands, which had been as inert as the rest of his body, had unsuspected skill and strength. He was put to work making models and lettering freehand maps to illustrate history lessons. Physical therapy and medical treatment improved Jack's health, but the social climate of the hospital class had equal therapeutic value in restoring him.

Another member of the class presented other problems for the teacher. A 15-year-old—we'll call her Betty—had polio when she was 7, necessitating a series of operations which kept her from attending regular school. Betty was a superior student, and there was no problem of "bringing her out"; but she had not learned to live with people. Determination to overcome handicaps made her intolerant and demanding and easily annoyed when she was crossed. With skillful handling by the teacher, her aggressiveness was directed into leadership activities, and the self-respect she gained encouraged her to improve her untidy apearance and unattractive personal habits. Betty is now a senior in high school, planning to be a secretary. When she came back to visit the hospital recently, she was an attractive, well-groomed, and poised young lady on crutches.

Many hospitals neglect child's education

These few examples demonstrate what can be done in the hospital for boys and girls—from small children in the impressionable years to young people going through the troubling years of adolescence. Yet in many hospitals even children of school age receive no organized education, in spite of the fact that most physicians recognize the therapeutic value of education as part of total care.

Our public-school system, which is responsible for providing education for all children, is also responsible for seeing that school comes to the child wherever he is. The objectives are not fulfilled, however, by giving a child only an hour or two a day of bedside tutoring, as is often done. The whole day must be considered, for the hospitalized child cannot run out to play after school hours or on week ends, nor can he always go home for holidays.

There are obvious advantages when a hospital school is connected with a board of education. It enables the board to set up a program, to assign qualified teachers, and to establish criteria for continued evaluation of the work. But neither the teacher nor the pupil should be confined rigidly to textbook lessons. There must be time and

Readers who are interested in learning more about opportunities for education for children in hospitals may be interested in the booklet, "Advancing the Education of the Hospitalized Child," the report of a conference held in Atlantic City, N. J., February 1948. Write for copies to the National Foundation for Infantile Paralysis, 120 Broadway, New York 5, N. Y. (Publication No. 72.)

New experiences come to these little hospitalized children through the characters in books.

opportunity to interpret learning in terms of living and for the interplay of group work.

Lack of such interplay is illustrated by the conditions in one orthopedic ward for teen-age girls, where the teacher goes from bed to bed listening to lessons. Propped up in various positions, her pupils write in their notebooks, with the one idea of keeping up with their grades. Much of the teacher's time is taken up with the red tape of public-school forms and reports. There is no give and take in this group: no visual material that all can share: no exchange of thoughts and opinions. It is a sterile atmosphere, and the girls do not look happy.

Quite a different situation exists at Goldwater Memorial Hospital on New York City's Welfare Island, where two trained and ingenious teachers manage to create a living experience for children too handicapped to return to normal life. Here boys and girls from 9 to 19, with varying disabilities, are wheeled into a large, airy room that looks across the water toward Manhattan. These ill children are grouped in the classroom, not always according to age, but according to their progress and learning ability. Each child presents a different problem for the teacher's help and encouragement. The children come together both morning and afternoon; and the program includes songs, storytelling, games, and films, as well as making puppets, decorations, and other things for group projects. Whatever his disability, each child is given a chance to participate. A boy too ill with a heart condition to do anything but observe is brought into this happy atmosphere to relieve him from the monotony of the wards.

Teacher brings the outside world to the child

Occasionally the Welfare Island teachers go out with pupils who are able to make field trips. For the others everything that is talked about must be explained and pictured—animals, a grocery store, trains, ships, machines. It takes imagination to fill the vacuities in the mind of a child who has known none of these things.

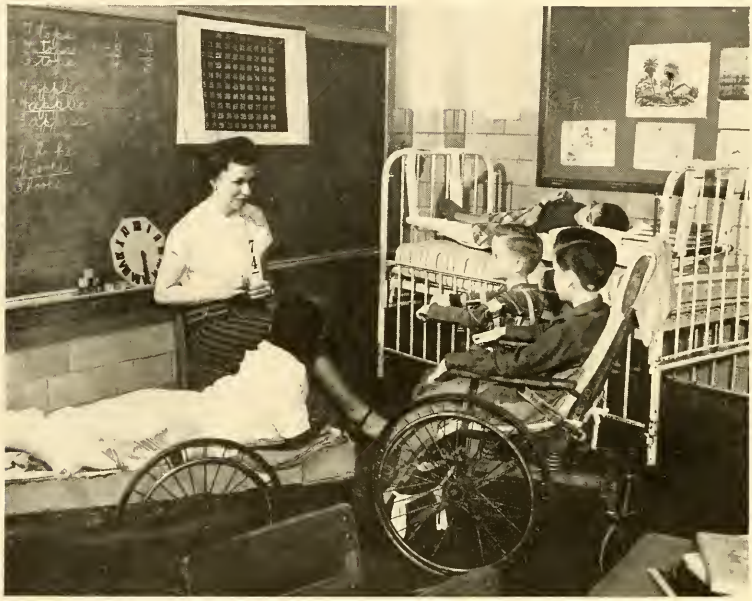
At Sunny View, Eastern New York Orthopedic Hospital, in Schenectady, teachers appreciate the delight children take in growing things. Patients have individual flowerpots to tend—plants which are their very own to watch and be responsible for. Beans are planted so that the children can observe germination. The group is divided into committees, according to the species they plant. Everyone helped when an indoor wildflower garden was developed. Visitors from the community brought plants, and the plumber made a huge pan for them from sheets of galvanized tin.

Elementary experiments in science bring great joy to children at Sunny View. So that bed patients may participate, the beds are protected with old sheets, and the youngsters are given trays to work on. With dry cells and wire the children make electromagnets, magnetize objects, test them at intervals, and keep a record of how long the magnetism lasts. Barometer cloth, soaked in a solution of cobalt chloride, is made into dolls and flags so that pupils may have the fun of forecasting the weather.

Mental and social progress must match or even exceed physical improvement if a child is to be in a true sense rehabilitated. This cannot be accomplished when little patients are left for long hours to their own devices. The preschool child particularly has been denied guidance and attention in hospitals. Confined to his crib like a prisoner behind bars, his only outlet lies

in toys that often are not carefully selected for their educational value. He attracts attention by throwing or destroying whatever he can get his hands on. Bad habits and frustration are the result, at a time when he should be learning good social habits.

At University Hospital, Ann Arbor, Mich., a whole-day program is carried out for children from 15 months of age to the high-school years, and is maintained 6 days a week for the 12 months of the year. The program is planned to fulfill the needs of the whole child, and it is set up around hospital routines and the medical schedule for each child's particular case.



No matter how severe his handicap, every hospitalized child can profit from group teaching.

For more social contacts with other children

To quote Mrs. Mildred H. Walton, supervising teacher, "The basic needs of an ill child are much the same as those of well children, except for some additional ones and more emphasis on specific ones. To combat the isolation that illness inflicts, the hospitalized child needs to do as many of the same things in the hospital as he would be doing at home or in a home school. He needs social contacts with other children and contact with the outside world. He has the usual emotional needs, with special need for reassurance, security, and freedom from fear."

At University Hospital there is a schoolroom, a workshop, and outdoor space on the roof. The daily program begins with a short play period. This period gives teachers a chance to help children needing social adjustment, to help retarded children in selecting and using toys, and to help restless children increase their span of attention by teaching them how to get maximum use out of toys and materials.

After the period of free play, the school program occupies the rest of the morning. Primary-grade children gather in front of the blackboard. They sit around a large low table, and those in beds or in wheelchairs are near by. Older boys and girls go to schoolrooms on another floor. Preschool children remain on the roof with their toys, as they are more happily situated there than in the wards.

At 11 o'clock all the children are returned to the wards for lunch and naps and at 2 o'clock they are brought back to the roof, to stay until 4. Boys and girls between the ages of 8 and 14 go to the craftshop if they wish, but this is entirely the child's choice. The first part of the afternoon is occupied with child-initiated activity, with the teacher encouraging group play. In the latter half of the afternoon the whole group, regardless of age, participates in some group project. This may be storytelling, a motion-picture film, music, dress-up play, or finger painting.

Student teachers from the University of Michigan School of Education give 6 hours a week to the hospital school. Under nine regular teachers, the students, through practice and observation, are oriented in the philosophy of teaching the handicapped. At weekly meetings, the education staff reviews the program together, shares experiences, and discusses techniques.

To be certified as qualified for this kind of teaching, requires, in Michigan, a minimum of 30 semester hours in special education courses. Teachers assigned to the hospital without special training are given temporary certification, based on their agreement to take 6 semester hours a year to fulfill the requirements.

Student nurses are also brought into the program by being relieved of their duties for a week to study under the supervising teacher. Toy cupboards, which nurses can draw from, are kept in each ward, stocked with educational and instructive toys for children of all ages.

A weekly meeting is held, attended by the education staff, occupational therapists, the librarian, and members of the social-service department. In the discussions of this group, plans are made for occupying the children's time while the teachers are off duty.

To carry out a successful program of hospital education, every member of the hospital staff must appreciate its importance in the plan for total care. This implies teamwork on the part of physicians, nurses, therapists, and, in fact, of everyone who comes in contact with the child. It is in his daily relationships with all these people that the child grows and develops. With the cooperation of the hospital administrator, the nursing supervisor, and others, treatment routines can be arranged so as to allow adequate time for a consistent education program and adequate space to carry it out. Granted, there is often a shortage of personnel and a natural tendency to obstruct

change; but with planning and a desire for and recognition of the need, the child's treatment, education, and recreation can be incorporated into an all-day program that allows him to live a more normal life. This entails utilizing available personnel to the best advantage.

Teacher should be recognized as part of team

Too often the school teacher is excluded from the hospital team and relegated to an extraneous position. She is accepted neither professionally nor socially as a bona fide member of the hospital staff. Her program suffers when she must "catch as catch can" to get enough time with her patients and enough facilities with which to work. Such a position, frequently underpaid, is not attractive to competent teachers.

Yet in institutions where the teacher's special contribution is recognized, she is often called on for valuable services beyond the call of duty. At University Hospital a little girl in a complicated apparatus was tearing her bandages in a state of emotional disturbance. A teacher who was called upon to help with the case interested her in doing something to occupy her mind and hands. Under the teacher's influence, the child became quiet and more content. At the Sigma Gamma Hospital, near Mt. Clemens, Mich., the teacher is informed when a child is to undergo special treatment or surgery. She discusses it with the children in the group, and the patient who is to have this treatment is helped to understand and to accept it. This helps to take away the frightened, hurt look in a child's eyes after he has undergone an operation.

To review principles of child development

It has been suggested that in-service training in the field of child development for all hospital workers might raise present standards. An orientation program, starting with basic principles and assumptions, would point nurses, social workers, teachers, and others in the same direction. Very few institutions have this correlation, although the principles are taught in professional schools for nurses, teachers, doctors, and social workers. What is lacking is a review and reemphasis of this training when the worker joins the staff of a hospital. Regular staff meetings, where all workers come together, are especially recommended.

Encouraged by a high-school teacher, these handicapped youngsters are having a lively discussion of current events. This helps to keep them in touch with the world outside.

As new hospitals are planned and built, provision for educational facilities should be kept in mind. In existing institutions, when space becomes tight and schedules crowded, the education program usually suffers.

War conditions hit hospital education

In one New York hospital, before the war, the whole top floor was given over to the teacher and her pupils, with excellent provision of space, light, and air. Under today's regime, the schoolroom has been reduced to a small, crowded area, with poor lighting and lack of storage space.

New hospitals should be planned to include a classroom, supply closets, and storage facilities near the wards. The room should be large enough to accommodate a group of children in beds, wheelchairs, or carts, and it should be well-lighted and attractively arranged. There should be enough space in wards for group work also. In a small hospital, where children who are long-term patients are few and far between, classroom space, when not needed for children, could be adapted to other uses—for adult patients' use, nurses' classes, or conferences. The important thing is to have the space available for children when they need it.

Although data on the number of disabled children in hospitals are incomplete, there is sufficient information to conclude that these children's needs are tremendous. Every day in the year there are some 3,300 patients in children's hospitals; 4,300 more in orthopedic institutions; and thousands more in general hospitals.

A survey within the past 5 years made by the Children's Bureau of the Federal Security Agency reports more than 341,000 crippled (badly handicapped) children in the United States. Infantile paralysis stands at the head of the list of causes, with more than 62,000 young patients. Cerebral palsy is next with more than 33,000. When we remember that in 1946, 1947, and 1948 there were approximately 64,450 new cases of infantile paralysis reported in the United States, we realize that children recovering from this disease remain one of our greatest obligations.

Community leaders can help a great deal in building a happy future for orthopedically handicapped children, especially in education, which is a vital part of therapy. First, local groups must find out how many such children there are in an area and what conditions prevail as to their care and education.

Volunteers in the hospital and board

(Continued on page 189)

TOWARD BETTER HEALTH FOR EVERY CHILD

American Academy of Pediatrics Reports to the Nation

ELDREDGE HILLER

NOW THAT the American Academy of Pediatrics has completed its 3-year Nation-wide study of child-health services, we know much more about what health services are available to the children in the 3,000 counties of the United States. And health planners can use this information as a base for positive and constructive action toward the goal of better health for every child.

Summary of findings available

The study was made with the help of the Public Health Service and the Children's Bureau, both of the Federal Security Agency. Substantial aid was given by the National Foundation for Infantile Paralysis: the National Institute of Health, Public Health Service, Federal Security Agency; the Field Foundation; and many leading commercial houses. The findings have been summarized in a report, Child Health Services and Pediatric Education, published by the Commonwealth Fund, New York City. A second volume is to be issued soon, giving the methods used in the study and basic tables from which the summary report was written.

The two-volume report represents the most comprehensive inventory of health services ever undertaken. It includes information from most of the practicing doctors in the United States; from all of the 6,000 hospitals that admit children; and from official and voluntary community health agencies. Also, since a study of child care must involve an evaluation of the training of the doctors who give the care, it reports the results of personal visits to each of the 70 approved medical schools in this country and all their affiliated teaching hospitals.

The general practitioner is the bulwark of child care

A startling result of the Nation-wide inventory comes from the answers of the physicians who have child patients—and most physicians do treat children. According to doctors themselves all too many gain their first real experience in the care of children *after* they enter practice. There should have been more opportunity for them to have such experience while in medical school and hospital internship. As it is, they get their training the hard way—from experience and from postgraduate courses and clinic work.

The problem of physician training for child care is directly traceable to the financial crisis in medical schools. High standards of medical education are being threatened by lack of funds for teaching budgets and by the resulting inability of schools to attract and hold the teachers who are needed to give the requisite clinical training.

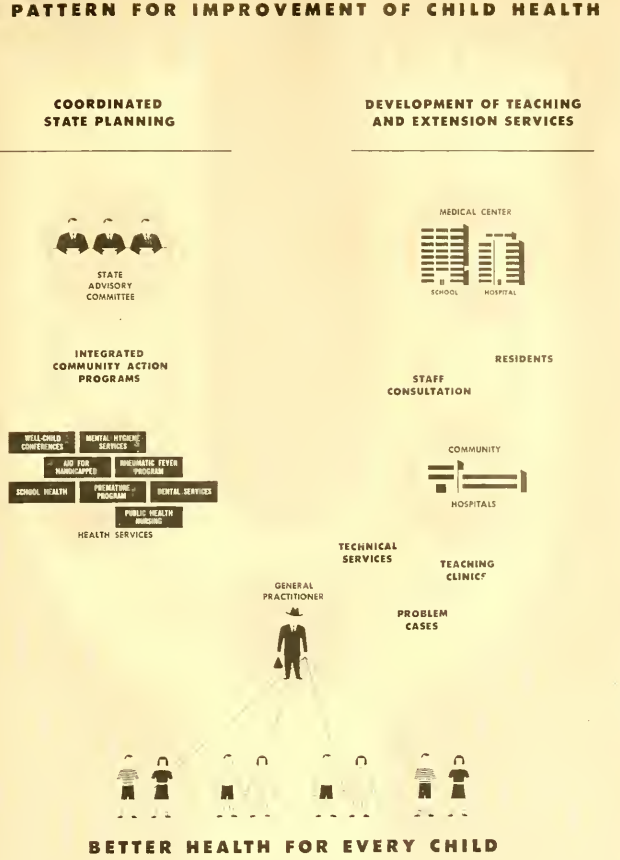
It is the undergraduate clinical teaching in hospital wards and outpatient departments that fixes in the medical student's mind the practical use of his classroom knowledge. This knowledge must be strengthened by providing him with more clinical teaching hours. That means more money to recompense teachers so that they can afford to take more time away from their private practice to teach.

The survey of medical schools shows that, although a few schools provide as many as 300 hours of clinical teaching in pediatrics for undergraduates, the average is only 161. And some schools provide less than 50 hours, which means that students are graduated from these schools having received less than 50 hours of actual contact with child patients in wards and out-patient clinics.

But when he receives his M. D. degree, the medical student is only beginning his practical training in child care. A period of well-rounded *graduate* training in a hospital, in which the doctor-patient relationship is established under faculty supervision, is essential preparation for good medical practice. Interns and residents, with the guidance they receive from experienced physicians, acquire sureness in applying their theoretical learning to actual child problems before they are thrust entirely on their own. Many students, however, cannot afford to acquire special hospital training. Financial aid in the form of fellowships must be increased to allow more physicians to round out their training as hospital interns and residents.

Family doctor needs pediatric training

The doctor who plays the greatest role in the care of the Nation's children, the study shows, is the general practitioner. Three-quarters of the private medical care of children in this country is in his hands. Of the Nation's 116,000 practicing physicians, two-



With the results of the Academy's local studies as a basis, State advisory committees are making plans suited to the needs of their individual States. All have the same objective: To make good medical care available to every child, regardless of who he is or where he lives.

thirds are general practitioners. And it is the family doctor who braves the rigors of country practice. Hospitals and diagnostic aid and specialists are few and far away. He must depend largely on his own judgment, skill, and resourcefulness. Thus, the Academy holds, it is particularly important to give the student preparing for *general practice* a good pediatric education while he is in medical school and good opportunities for graduate hospital training in child care.

Once in practice, the busy family physician has little opportunity to take postgraduate courses, to catch up and keep up. It is therefore, important to extend or "beam," directly from medical centers, the postgraduate training and special diagnostic and therapeutic services that our practicing physicians, especially the remote country doctors, need and want in order to provide up-to-date child care.

In some sections of the United States plans for "decentralizing," or extending training and services from medical centers directly to isolated communities, are being developed by philanthropic foundations, State and county medical societies, and medical schools. Where the programs are in effect, a high quality of medicine is being brought directly to the most remote communities. The Academy's program at the national level is adapting these techniques in a demonstration program which it has just started and which it hopes will ultimately encourage heads of pediatric departments in all medical schools to disseminate their services to regions surrounding their medical centers.

Before describing that program, however, let us take a brief look at the county-by-county study which the Academy's State chairmen conducted throughout the Nation with the cooperation of public and private health and medical organizations.

County-by-county score revealed by the State studies

There is a geography of health that is linked closely with the geography of medical care, the local studies showed. In some counties where modern medical services are scarce, five times as many infants (per thousand live births) die as in more favored communities.

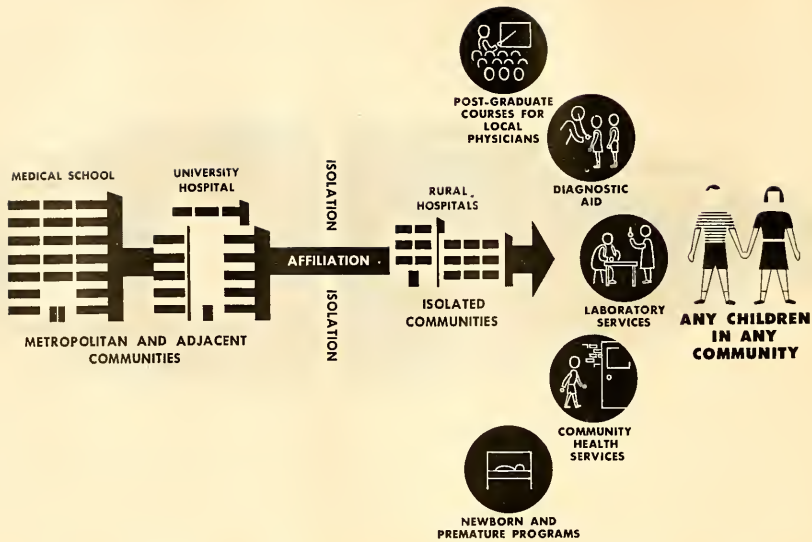
Children in or near cities receive 50 percent more care than those in isolated counties—areas to which the advantages of metropolitan areas are not readily accessible. Two-thirds of the 3,000 counties in the United States are in this category. Children in these areas particularly lack specialist care, clinic care, and the highly skilled diagnostic and treatment services that are available to their city cousins.

Hospital out-patient services are almost nonexistent outside the metropolitan counties. Some States provide over three times as much hospital care for children as others do. One State has five times as many physicians as another in relation to child population.

Community health services such as public-health nursing, clinics for physically handicapped children, well-child conferences, and premature-infant and rheumatic-fever programs are not filling the gaps left by private practice.

Two over-all needs

Therefore, if one were to distill from the entire 3-year study of child-health services the two most significant con-



When rural hospitals are affiliated with a medical center, modern medical care is available to children in isolated communities.

clusions, these would be, in informal phrase: We need to do something about the medical training of all physicians—general practitioners as well as pediatricians—to give them the best possible preparation for child care; and we need also to make it possible for children in isolated areas to have the same opportunities for good care that they have near our large medical centers.

Thus we are brought back to the original objective that prompted the study: How to make quality medicine available to all children, regardless of where they live or the income of their parents.

The study was from the outset recognized as only the first step. Now that the Academy has answered the question "What is?" there is ahead the far more difficult question, "What to do about it?" That is, how to meet the needs that have been revealed.

The Academy is not leaving future action to chance. It has created a continuing committee, aptly designated the committee for the improvement of child health. This committee, under the chairmanship of Dr. James L. Wilson of the University of Michigan, is made up of pediatricians in private practice and in academic and administrative positions. Under the executive direction of Dr. John P. Hubbard, who also directed the study, the committee has established offices in Philadelphia, and it is already well along the road on the important assignment of translating the study into positive action. Also, to dovetail the child-health program with State and county health programs, the Academy and the American Medical Association each has appointed a three-man liaison committee for cooperative planning and effort.

A twofold solution

To meet the twofold need—more training for doctors who are caring for children and a better distribution of medical care—a twofold solution has evolved. Through extension of pediatric education and services to outlying areas, fresh knowledge is brought to the hard-pressed general practitioner, and the skills and up-to-date methods of the medical centers are brought to the children in the areas where deficiencies have been shown to exist. Through creation of opportunities for graduates of medical schools to receive portions of their training as pediatric resident physicians in outlying hospitals that become affiliated with teaching centers, many advantages result simultaneously. More places are provided to train more residents and hence turn out more well-trained physicians; community hospitals benefit by the services of a resident that they would not otherwise have had; the resident himself profits from a period of very practical training; the local general practitioner is on the receiving end of a direct channel from the medical center; and the child, even in remote and isolated areas, receives better medical care and health supervision. Thus immediately we are brought closer to our goal of better health for every child.

To give practical application to this broad planning, the committee has worked out a demonstration program for decentralization of teaching and services. Stemming from a large university medical center, this program is

being developed in three Eastern States. Under this set-up, small hospitals, through affiliation with the large pediatric teaching hospital of the medical center, will be brought into close touch with metropolitan services and its modern techniques. The residents gain practical first-hand experience in the art of rural medicine, but they also serve while they learn. Their services increase the hospital's usefulness and their active participation in community health services brings forth new well-child clinics and similar health aids.

However, no over-all national program can be effective without initiative and support by the States and the communities. If children's health is to be brought up to a uniformly high level everywhere in the United States, with better health and medical services reaching into every community, State programs inspired by local medical and health organizations must be developed along with national programs.

Thus the Academy's own State chairmen are preparing State reports and detailed operating plans suited to the needs of the individual States.

The study findings have already been reported and published in Florida, Louisiana, Mississippi, Missouri, New York, North Carolina, Oregon, South Dakota, and Wisconsin. Sixteen others are in draft form.

In some States, under the auspices of the State chairmen, new committees or councils for the improvement of child health have been formed, or the representation of the existing ones has been broadened. Membership includes representatives from pediatric societies, State and local medical societies, health departments, and other organizations in the States which are active in child health and welfare.

Reports of local studies bring action

Recommendations by the State committees, based on the local study reports, are urging the expansion of many public-health programs, including the establishment of more community health services such as public-health nursing, immunization programs, mental-hygiene clinics, and aid for the physically handicapped. Recommendations involving better public-health measures have in some instances stimulated official action at the State capitals.

A tangible illustration of the value of the State findings was demonstrated in one Western State. A plan for a children's hospital had been canceled by the Governor on the ground that there was no need for it. The findings of the Academy's State study were brought to his attention, and as a result the hospital is now under construction.

Hospital administrators are acquiring constructive suggestions from these reports for improvement of their own services. But through all the State reports echoes a need for greater consideration of the trials and tribulations of the general practitioner—better training, extension of postgraduate education to him in his own community, and provision of special consultation and diagnostic aids when he is far away from cities.

The common denominator of the Academy's plan is better opportunities for all children

Reducing the idea to simple terms, the Academy says that under modern medicine your child and my child and the next child are entitled to protection of their health and to good medical care when they are sick.

That means health supervision from the time of birth in such matters as proper feeding, and immunization against diphtheria, smallpox, and whooping cough. It means continuing supervision to keep well children well during their preschool and school years. It means skilled medical attention for the sick child by a doctor who, whether specialist or family physician, is adept through training and experience at recognizing and treating childhood ailments; who can have advice from consultants on the diagnosis and treatment of difficult cases; who is versed in new drugs and therapies.

If your child and mine have these benefits, they are indeed fortunate. But until all children have them, there will continue to be youngsters growing up with defects unchecked or uncorrected, and there will continue to be many in whom diseases such as rheumatic fever gain fatal foothold for lack of early diagnosis and care.

Now for a vigorous action program at National and State levels to get good care to the *other* child.

Reprints in about 4 weeks

HOSPITALIZED CHILDREN

(Continued from page 185)

members of community agencies can lead in studying legislation and appropriations to improve conditions. Their interest can result in the appointment of well-prepared, well-adjusted teachers in this highly specialized field, at salaries adequate to attract other competent teachers to enter it.

Volunteers can also aid in supplying materials to teachers and occupational therapists; these may include special books, selected toys, wall cabinets, bedside storage cabinets, earphones for radio sets, motion-picture projectors, and films. They can promote plans for developing teaching space: for example, covering the roof, building an additional schoolroom, converting rooms already built. To keep a full-day and week-end program going, teachers can well use volunteer services in manning book carts, telling stories, and operating motion-picture projectors, as well as in other group activities.

Volunteers work under teacher's guidance

Volunteer groups have always been generous in bringing entertainment to hospitals, but *passive* looking and listening will not give children as much as *active* recreation, in which they have a chance to learn something and to express themselves. Under the guidance of the teacher, volunteers can help children create and plan plays, parties, musicales. Original work by the children is a release for their emotions and an encouragement for social growth.

The lives of hospitalized children are enriched, too, by trips to outside schools and other interesting places in the community. Volunteers can solve the problem of transportation and act as guides and attendants. To be taken to a ball game, or wheeled through a museum, or even given an ice-cream cone from the traveling ice-cream cart, means to the handicapped child being normal and, for the moment, a part of the life outside. Through these simple experiences he may be made ready for home and for companionship with other children when he leaves the hospital, without the shock of readjustment to a world which has become strange.

Reprints in about 4 weeks

HOME HELPS

(Continued from page 181)

specialists in every phase of the work. Emphasis is always on the practical problems that will meet organizers or are already facing them. An attempt is made to build up a high sense of professional vocation and to demonstrate the backing that every organizer will get.

We look to the future

In July 1948 the famous National Health Service Act came into force. This provides for a free, comprehensive health service from cradle to grave. The cost is met by taxation and to a small extent by compulsory insurance. It is a most ambitious all-round public-health service. The Minister of Health stated that home helps are an integral part of the service, and that the work of the family doctor and home nurse will be seriously hampered unless there are adequate home-help services throughout the country. This home-help service is free to those who are unable to afford to pay for it. A great many authorities already have adequate home-help services. All the rest are able to show that their plans are well-advanced. There is some years' work ahead, but there are already many thousands of home helps, and some places have reached the ideal target of one home help per thousand population.

Britain is going through many social changes; even the pattern of home life is changing. But the family ideal is not deteriorating, and there will be a great tendency in the future to strengthen the practical supports. We are building houses as fast as we can, giving them precedence over hospitals. The health authorities talk increasingly of "home care"—all the services that simplify and sustain home life, especially in times of emergency and illness. Among these services home helps are making a growing contribution, simplifying the work of doctors, preventing illness, relieving hospitals, enabling old people to live at home rather than go into group care, but still first and foremost helping mothers and children.

Reprints in about 4 weeks

IN THE NEWS

Venezuela Publishes New Official Child-Welfare Periodical

Infancia y Adolescencia is the title of a new bimonthly periodical published in Caracas, Venezuela, by the Venezuelan Council of the Child. The Council, an official agency, is concerned with problems of child dependency and neglect.

The first number, dated January–February 1949, gives much space to day-care centers established by the Council.

Of attractive format and abundantly illustrated, the periodical is edited by Dr. J. A. Rodriguez Delgado, secretary general of the Council. A message of greeting to other child-welfare periodicals at home and abroad introduces the newcomer.

Nearly 5,000 Boys and Girls Found Illegally Employed Under FLSA

Child-labor abuses continue in many States, even after 10 years of enforcement of the Fair Labor Standards Act. This is revealed in the 1948 annual report of the Administrator of the Wage and Hour and Public Contracts Divisions, U. S. Department of Labor.

The report shows that 4,628 boys and girls under 18 years of age were found employed in violation of the act's child-labor provisions. More than three-fourths of these were 14 or 15 years of age. Forty-eight of the children were 12 years of age or younger—one was only 7. Violations of the act were disclosed in 1,384 of the 28,998 establishments covered by the act which were inspected during the fiscal year.

The FLSA sets a 16-year minimum age for most jobs, an 18-year minimum in jobs declared to be particularly hazardous, and a 14-year minimum for a limited number of specified jobs for work only outside school hours under certain conditions.

One in every six of all young persons under 18 found employed in the establishments covered by the act which were inspected was illegally employed. Child-labor violations were found in every major industry group, but the highest percentage was found in fresh-fruit and vegetable packing sheds, where three out of every four of the employed young persons were illegally employed. In sawmills and planing and plywood mills, two out of three of the employed children were under the legal age for the jobs at which they were working. One out of every two of the children who worked in laundries and dry-cleaning plants was illegally employed.

Under-age workers were found employed in 16 percent of all canneries inspected.

Summer Courses

Boston University. School of Social Work, Boston, Mass. Courses include, among other subjects, social services for children and interviewing in social work (second series, July 11–August 20).

University of Chicago. School of Social Service Administration. Chicago 37, Ill. Two 5-week summer terms, June 28–July 29 and August 1–September 3.

The sessions are planned especially for two groups of students: (1) Those working for the master's degree, who will find all basic courses and field work offered, and (2) experienced social-service workers who have this degree but wish to learn new developments in the field and broaden their professional preparation.

Field-work courses, open only to full-time professional social-service students: Basic field work, child welfare, medical social work, psychiatric social work, administration, community organization, research and statistics, and advanced family welfare.

University of Buffalo. School of Social Work. Buffalo, N. Y. Courses in case work; psychiatric social work; public welfare; family relations; and child welfare (July 5–August 27).

FOR YOUR BOOKSHELF

YOUR CHILD'S MIND AND BODY; a practical guide for parents. Flanders Dunbar, M. D., Random House, New York, 1949. 324 pp. $2.95.

Physicians and mothers who must deal on a day-to-day basis with children often get the impression that psychia-

trists are unduly critical of usual child-rearing methods, and thus feel a need for the psychiatrists to suggest alternate and possibly better methods. In this book Dr. Dunbar fulfills part of this need. But in so doing she takes the risk of being often too positive, and of tending to lump facts and theories, presenting them all as facts.

The author is at her best in helping parents to recognize the advantages of assisting a child to learn rather than formally teaching him. She applies this principle well to the normal concern of the mother with feeding, toilet training, and sleep. In general, however, there seems to be a lack of warmth in her approach to the mother-child relationship.

The book has excellent paragraphs on the development of honesty and on the ways in which we often tend to confuse mere errors with "sin."

It includes such neat aphorisms as "Hazy parents have hazy children." Observing that "to pass on happiness you must yourself be happy," Dr. Dunbar adds, "To be happy and to give happiness are a parent's privilege and responsibility."

The blunders that parents make are well-described, but the danger of putting the burden of guilt on the child is so repeatedly mentioned that the book tends at times to become a severe criticism of parents and to leave scant room for any error on their part. Frequently it seems as though Dr. Dunbar also puts a burden on the parents by expecting from them psychological diagnosis and therapy. And many physicians will fell slighted by the manner in which she refers to their efforts in that direction (however truly these efforts may be described).

Throughout the book Dr. Dunbar has made excellent use of case histories, but her cases seem to come from a select group of intelligent children, well-supplied with nurses and governesses. She gives a curious picture of the mother—usually a working, professional person who sees her child only in the evening to discuss his daily difficulties. And the children speak in a fashion more erudite than one is accustomed to hear in daily practice.

In many ways this book seems more useful as a text for professional people than as the practical guide its title proclaims it to be. Mothers will probably prefer to stick to Spock.

Henry H. Work, M. D.

FORTY-FIVE IN THE FAMILY: the story of a home for children, by Eva Burmeister. Columbia University Press, New York, 1949. 247 pp. $3.25.

The "family" in this book are 45 boys and girls of elementary-school age who are receiving residential care at Lakeside Children's Center, Milwaukee, Wis. Miss Burmeister is the director of the center.

The fact that this is an old congregate institution makes its accomplishments stand out. It shows that lack of modern facilities does not necessarily prevent warm, friendly relationships, a comfortable environment in which children can develop, and a program that is full of meaning to children.

Although the agency centers its program on the individual child, it gives equally sympathetic understanding to the housemother. Relationships between child and housemother are emphasized, as well as the "homely, earthy, realistic duties connected with the physical aspects of child care." Recognizing that even staff members with the highest qualifications have much to learn, the institution provides for in-service training.

In the chapter, Something Smells Good, which discusses the institution kitchen and what it means to the children, the author urges that there be more giving than withholding in institutional work.

The book points out that children like, and need to have, adults play with them and that part of the housemother's responsibility is to plan and participate in the children's play. In a larger institution, or one in which housemothers are responsible for large groups of children, Miss Burmeister believes that a recreation director should be on the staff. All child-welfare workers will agree that a play program should follow the principle expressed by Miss Burmeister that "true recreation is participation, not observation."

Other chapters include such subjects as the Men in Our Lives, Bedtime, Children's Books and Reading, Bicycles, Pets, Work and Work Attitudes, the Garden, Discipline.

What case workers do is clearly set forth—intake, placement, work with relatives, direct work with children in residence. The author also takes up relations between child-care and case-work staffs.

The discussions of the personalities of children and staff alike are full of human interest, and will be enjoyed by anyone fond of children.

Own parents, as well as foster mothers and housemothers, will learn much from this book about children and successful ways of teaching them to live with others. For persons associated with an institution for children this book is "must" reading. Real pleasure is in store for all who read it.

I. Evelyn Smith

THE CHILD IN HEALTH AND DISEASE: a textbook for students and practitioners of medicine, by Clifford G. Grulee, M. D., and R. Cannon Eley, M. D. Williams & Wilkins Co., Baltimore, 1948. 1,066 pp. $12.

Seventy-five outstanding authorities in various pediatric fields have contributed sections to this textbook. A vast amount of up-to-date information on a wide range of topics, including growth and development, nutrition, the newborn, the adolescent, acute and chronic diseases, and the various body systems is concisely presented. References are given at the end of most chapters, and though not numerous they are well-selected and helpful.

The book is written as a guide for students and practitioners of medicine to help them to make practical application of the scientific advances of investigators in the lives of real children. There is variation in quality of the subject matter, as is almost necessarily true of a multi-authored book; and though there is recognition of the emotional needs of the child, the emphasis is chiefly on the physical aspects of care.

Alice D. Chenoweth, M. D.

CALENDAR

July 2–9—Second Pan American Congress of Social Work. Rio de Janeiro, Brazil.

July 4–8—National Education Association. Boston, Mass.

July 12–17—National Association for Advancement of Colored People. Los Angeles, Calif.

July 18–22—Second International Congress for the Education of Maladjusted Children. Amsterdam, Holland.

Illustrations:

Cover, Esther Bubley for Children's Bureau.

Pages 178 and 181, Pictorial Press, London, England.

Page 180, Odhams Press, Ltd. London, England.

Page 183, Charles Roland Burd for University Hospital School, University of Michigan, Ann Arbor.

Pages 184 and 185, French-Yager for Toledo (Ohio) Society for Crippled Children.

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PRENATAL CARE—1949 MODEL

More than a third of a century has passed since the Children's Bureau issued its first booklet for parents, Prenatal Care. Since that first edition, this publication, like the Bureau's other bulletins for parents, has gone through a number of revisions, which have kept it up with the newest scientific thought. And in its latest edition, which has just come off the press, it has been completely rewritten.

When Prenatal Care was first published, in 1913, its chief aim was to point out and stress the need of medical care during pregnancy. And the 1949 edition makes clear that continued medical care during pregnancy is just as important as it has always been.

But today the concept of good care for mother and baby has broadened. We think more in terms of "maternity care," which includes medical supervision from early pregnancy through the birth of the baby and for several weeks later. And as in all previous editions, the new Prenatal Care sets as the goal of such care a healthy mother and baby, after a comfortable pregnancy and an easy labor.

Although the goal of maternity care remains the same through the years, some of the ways in which we strive to attain this goal have changed, and the 1949 edition of Prenatal Care reflects these changes.

For example, no earlier edition included, as the 1949 one does, a chapter telling how the baby grows before birth, with large, simple drawings to make the process clearer. In 1913 such a chapter would have shocked many readers.

Incidentally, the franker attitude of the present day toward pregnancy has brought about increased willingness of expectant parents to read books about care of the mother before the baby is born. The demand for Prenatal Care, for example, has greatly increased in recent years—much more rapidly than can be explained by the larger number of infants being born.

The new chapter on development of the embryo is one of those planned to help the mother and father understand better the physiological aspects of having a baby, but the booklet as a whole stresses more the psychological aspects. This emphasis is strong in the discussion of breast feeding and bottle feeding in relation to the emotional needs of the baby. And a whole chapter is devoted to the thoughts and feelings of the mother.

Another more modern trend reflected in the booklet is the increasing recognition of the importance of the rest of the family in relation to the baby. A chapter beginning, "When should you tell the other children about the new baby?" goes on to suggest ways in which children can be drawn into the plans for the newcomer.

"This Is a Family Affair," which might well be the title of the booklet, is the heading of a chapter written for the baby's father. This includes the words, "It is just as important for a father-to-be to read all of this bulletin as it is for his wife."

Introducing the new booklet, Oscar R. Ewing, Federal Security Administrator, says: "Doctors have known for a long time that mothers who are well-prepared for their expected babies stand the best chance of having healthy, happy ones.

"Now, more than ever before," the Administrator continues, "doctors say that being well-prepared is not only a matter of the mother's keeping physically well throughout pregnancy. Such preparation means also that both father and mother are emotionally ready and eager to welcome the arrival of their new baby.

"Here is a bulletin," Mr. Ewing goes on, "that helps both mothers and fathers to prepare for parenthood. It does not take the place of a doctor, but supports the advice and guidance he gives."

"I know of no other single element in our many-sided effort to build abounding good health in all our people," concludes Mr. Ewing, "that is more important than this one of assuring to every child the best possible start in life."

VOL. 13, No. 12 JUNE 1949

the CHILD

published monthly by the
Division of Reports
CHILDREN'S BUREAU
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Publication of THE CHILD, monthly bulletin, was authorized by the Bureau of the Budget, May 12, 1926, to meet the needs of agencies working with or for children. The Children's Bureau does not necessarily assume responsibility for statements or opinions of contributors not connected with the Bureau. THE CHILD is sent free, on request, to public officials and libraries; address requests to the Children's Bureau, Federal Security Agency, Washington 25, D. C. For others, the subscription price is $1 a year; send remittance to the Superintendent of Documents, Government Printing Office, Washington 25, D. C.

U. S. GOVERNMENT PRINTING OFFICE: 1949